KNOW YOUR BENEFITS

2005 MARICOPA COUNTY EMPLOYEE AND SPECIAL HEALTH CARE DISTRICT BENEFITS PLAN

The information in this booklet highlights the Maricopa County and Special Health Care District benefits plan for employees and their dependents.

This booklet is intended to provide you with information needed to make informed decisions regarding the selection of your benefits. The benefits described herein are summaries of the County's official plan documents and contracts that govern the plan. In the event of a discrepancy between the information in this booklet and the official documents, the official documents govern.

Maricopa County reserves the right to change or cancel its benefits plan, in whole or in part, at any time.

Participation in any of the County's benefits plan is not a contract of employment.

HOW TO OBTAIN BENEFIT INFORMATION

Information about the benefits plan is available on the Internet at www.maricopa.gov/benefits or on the Electronic Business Center (EBC)/Intranet at ebc.maricopa.gov/hr/benefits.

(Both of these Web sites are referred to as the "Benefits Home Page" in this document.)

You may also e-mail the Benefits Office at BenefitsService@mail.maricopa.gov or, for plan information, call 602-506-1010 from 8 a.m. to 5 p.m. MST Monday- Friday.

The Benefits Office can assist you with general questions related to premiums, eligibility and enrollment, status changes, and benefits continuation while on leave of absence (LOA) and/or upon retirement.

Please contact the specific vendor for answers to detailed benefit questions regarding coverage, costs and claim(s) payments. Vendor contact information is located in the "Who to Contact" section of this booklet.

The words "you" and "your," when used in this document, refer to the employee. The word "we," when used in this document, refers to Maricopa County. The words "benefits plan" and "plan" used in this document refer to the Maricopa County Employee Benefits Plan. The term "Benefits Office" refers to the Maricopa County Employee Health Initiatives Department Benefits Office.

This booklet contains a summary of your benefits under the Maricopa County Employee Benefits Plan. If you have difficulty understanding any part of the document, contact the Benefits Office, located at 301 W. Jefferson St., Suite 201, Phoenix, AZ 85003, 8 a.m.-5 p.m. Monday-Friday for assistance.

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Esta guia contiene un resumen de sus beneficios correspondiente al plan de beneficios para empleados del Condado de Maricopa. Si le es dificil entender cualquier parte de este documento, contacte a la Oficina de Beneficios localizada en 301 W. Jefferson St., Suite 201, Phoenix, AZ 85003, 8 a.m.-5 p.m. de lunes a viernes.

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INTRODUCTION

Maricopa County recognizes your valuable contributions as an employee by offering comprehensive benefits for you and your dependents through the Employee Benefits Plan. Maricopa County is committed to helping you handle the high costs of health care, the risks of lost income due to illness and disability, and preparing for a secure retirement. The County's benefits plan provides:

- A choice of eight medical plans;
- A vision benefit;
- Behavioral health and substance abuse services;
- An Employee Assistance Plan (EAP);
- A choice of two dental benefits;
- Basic life, accidental death and dismemberment, supplemental and dependent life insurance benefits;
- Short-term disability (STD) coverage;
- Health care and dependent care flexible spending accounts (known as Mariflex);
- A deferred compensation plan;
- Discounts on auto, home and renters insurance;
- Critical illness coverage; and
- Arizona State Retirement System (ASRS) benefits, which include a long-term disability program, or Public Safety Personnel Retirement System benefits. Please visit www.asrs.state.az.us or www.psprs.com for details.

WHO'S ELIGIBLE?

You can participate in the benefits plan if you are a regular employee (except some contract employees as specified below) scheduled to work at least 20 hours per week. You must participate in a retirement plan, if eligible.

For benefits plan purposes, "regular employee" is defined as a full-time or part-time employee who is not temporary, but who may be a contract employee. **Please note:** When related to benefits administration, the definition herein of a regular employee differs from that used in the Merit Rules, available online at http://ebc.maricopa.gov/pp/hr/tocs/EmpMerit_TOC.asp. Employees working under specific contracts may or may not be eligible for benefits based on the terms of their contract. Each appointing authority, in conjunction with the Employee Health Initiatives Department, determines whether contract employees are benefit eligible.

Regular employees (except some contract employees as described above) scheduled to work less than 20 hours per week and all temporary employees are not eligible to participate in the benefits described in this booklet except for the EAP, auto, home and renters insurance; critical illness coverage and deferred compensation.

ARE DEPENDENTS ELIGIBLE?

Your legal spouse and/or your unmarried dependent child(ren) are eligible for coverage if the dependent meets the definition, conditions and limitations of a child and dependent.

The term "child" means your unmarried natural child, stepchild, legally adopted child, child placed with you for adoption or child for whom you have been awarded legal guardianship. The term "dependent" means a child who meets one of the relationships listed above, who resides with you or who is temporarily absent due to school attendance or a custodial arrangement, and for whom you provide at least half of the support.

The definition of "dependent" is subject to one of the following:

- Your unmarried dependent child(ren) under 19 years of age.
- Your unmarried dependent child(ren) 19 years of age or older, but less than 25 years of age, if he/she is a full-time student (as defined by the school) at an accredited institution of higher education. Your student dependent will remain eligible during summer breaks from school provided that he/she will be attending school on a full-time basis for the fall term/semester.
- Your unmarried child of any age who resides with you and who was medically certified as disabled prior to his/her 19th birthday (or 25th birthday if disabled while a full-time student) and who is primarily dependent upon you for support and maintenance.

- Your child for whom health care coverage is required through a Qualified Medical Child Support Order or other court or administrative order(s) — even if he/she does not reside with you. Copies of the applicable pages of the support order are required for documentation.

You must provide verification of continued eligibility as a student or disabled child dependent to the Benefits Office when your dependent turns 19 and then at the beginning of each semester for a full time student. Additionally, the medical and dental vendors will ask you to provide verification of student dependent status and/or disabled child eligibility. Failure to provide such verification will result in termination of dependent coverage.

You are responsible for immediately notifying the Benefits Office when your dependent **becomes ineligible** for coverage. **You are liable for the costs of all services covered under the benefits plan for your dependent who is ineligible on the date of service.**

WHEN DOES COVERAGE BEGIN FOR NEW BENEFIT-ELIGIBLE EMPLOYEES?

You have up to 30 calendar days from your hire date to elect and submit your enrollment form with your benefit elections to your department's Human Resources (HR) Liaison, to the Maricopa County Employee Benefits Office or online through Employee Self Service at http://my.maricopa.gov. Once you submit your enrollment form and your enrollment is processed, no changes are allowed, even if the 30-calendar-day period has not expired. Benefit coverage for a newly hired employee begins the first day of the month following your date of hire. Current employees transferring to a benefit-eligible job and who complete the enrollment process within 30 calendar days of their transfer date are covered beginning with the transfer date. Your benefit deductions begin the first day of the pay period in which your coverage beginning date falls.

If enrollment online through Employee Self Service or with a completed enrollment form is not received by the Benefits Office or your department's HR Liaison within 30 calendar days of your hire date, your medical coverage will default to the HealthSelect Low Option and your pharmacy coverage to the Consumer Choice Rx plan for single coverage for yourself. Your basic life insurance coverage will default to an amount equal to your annual salary rounded up to the next highest thousand dollars. You will not be enrolled in either dental plan. Your default coverages will be effective on the first day of the month following your date of hire. To prevent a retroactive premium adjustment to your paycheck and to preserve your choice of benefits, the enrollment form or online enrollment should be completed and submitted as soon as possible. If you do not want any coverage under the County's medical benefits and you are covered under other health insurance, you may waive coverage under the County's plan by advising the Benefits Office on the enrollment form or through online enrollment. Should you decide to waive your coverage because you are covered under other group health insurance, you may qualify for compensation. Refer to the "Compensation for Waiving Medical Insurance Coverage" section.

After benefit elections have been submitted to the Benefits Office, no change (additions or deletions of covered dependents or changes between plans) in benefits will be allowed until the next open enrollment period, unless you have a qualified status change as defined under the Internal Revenue Code (IRC) Section 125. Please note that if you were employed by Maricopa County, terminated employment and then were re-hired within 30 calendar days, the benefit elections in place before your termination will be reinstated with no break in coverage and no option of changing your elections unless your termination occurred after you made an open enrollment change. In this case, your open enrollment changes will be honored for the next plan year. Refer to the following sections in this booklet for more information: "When Can You Make Changes?" and "What is a Qualified Status Change?"

Open enrollment occurs each year, generally in late October through early November for a Jan. 1 effective date. Open enrollment dates are posted on the EBC/Intranet and communicated to each department. Please check with your department HR Liaison, Employee Benefits Advisory Council (EBAC) member or the Benefits Office to get specific dates of the next open enrollment period. A listing of HR Liaisons and EBAC members is available on the Benefits Home Page.

HOW TO ENROLL

You should attend a New Employee Orientation (NEO) meeting to receive benefits plan information. You can complete your enrollment online through Employee Self Service or submit a customized enrollment form that is sent to your HR Liaison within 30 days of your hire date. It is in your best interest to complete and submit your online enrollment or your paper enrollment form as soon as possible. Refer to the "When Does Coverage Begin for Newly Hired Employees?" section for more information.

If you are not scheduled to attend a NEO meeting, you have the following additional enrollment options:

- Ask your HR Liaison for the enrollment materials.
- Go online to the Benefits Home Page to obtain the benefits plan information you need to make your choices.
  - The EBC/Intranet address is: **http://ebc.maricopa.gov/hr/benefits**
  - The Internet address is: **http://www.maricopa.gov/benefits**
- Contact the Benefits Office via e-mail at BenefitsService@mail.maricopa.gov, via the Internet or by using the Microsoft Outlook Global Address List.
- Call the Benefits Office for information at 602-506-1010.
- Visit the Benefits Office at 301 W. Jefferson St., Suite 201, Phoenix, AZ 85003.

WHO PAYS FOR MEDICAL AND DENTAL COVERAGE?

EMPLOYER CONTRIBUTION

Maricopa County or the Special Health Care District makes a contribution toward the cost of the premiums for your medical and dental plans. You have the option of selecting medical coverage from one of two medical vendors: HealthSelect or CIGNA, and to select dental coverage from one of two dental vendors: Employers Dental Services (EDS) or United Concordia. The medical plans are described in the "Medical Plans" section. The dental plans are described in the "Dental Plans" section.

If you are normally scheduled to work full time (30 or more hours per week), you will receive the maximum, full-time County or Special Health Care District contribution towards your premium for either the HealthSelect or the CIGNA medical benefit plan for you and your dependents.

If you are normally scheduled to work **part time** (20 to 29.99 hours per week) and enroll with **HealthSelect,** you will receive the **maximum, full-time County contribution** toward your premium for the HealthSelect medical benefit plan for you and your dependents. If you select this advantageous option, your premiums will be the same as those of a full-time employee.

If you are normally scheduled to work **part time** (20 to 29.99 hours per week) and enroll with **CIGNA**, you will receive a **lower County or Special Health Care District contribution** toward your premium for the CIGNA medical benefit plan for you and your dependents. This means you will pay more in premiums for the CIGNA medical benefit plan than would an employee who works full time and selects CIGNA or an employee who works part time and chooses HealthSelect.

The County or the Special Health Care District contributes the same amount toward your dental elections for the EDS plan whether you are a full-time or a part-time employee. If you are a part-time employee and elect dental coverage through United Concordia, the County or Special Health Care District contribution is lower.

EMPLOYEE CONTRIBUTION

When you elect coverage, you authorize the County or Special Health Care District to deduct the current employee benefit premiums from your paycheck for each benefit option you elect. Payroll deductions will be made from the first two paychecks of each month, 24 paychecks per year. However, since there are 26 paychecks per year, two paychecks have no benefits deductions, with the exception of those for the Mariflex flexible spending accounts (FSAs).

You are responsible for reviewing your paycheck stub to verify that the correct premium deduction amounts are taken for the benefit options you elected. Please refer to the premium rates in the "2005 Premium Rates" section.

If the premium deductions on your paycheck are incorrect in that you have been charged a higher amount due to an administrative error, and you identify the problem in writing to the Benefits Office within six months from the date the error began, your premiums will be adjusted to reflect the correct amounts from the date of the error. Errors discovered after six months will be corrected on a prospective basis with no refund on the overpaid premium. Regardless of when an error is discovered, if your premium deduction is incorrect in that you have been charged a lower amount than you should have paid, your premiums will be adjusted retroactively to the date of the occurrence and you will be responsible for the full cost of the underpaid premiums.

Deductions for the medical (which includes pharmacy, vision, wellness, benefit contracts and behavioral health/substance abuse benefits), dental and health care and/or dependent care FSAs reduce your taxable income, thus saving you money that would otherwise be paid in taxes. This tax advantage is provided under and follows the provisions of IRC Section 125.

COMPENSATION FOR WAIVING MEDICAL INSURANCE COVERAGE

The County will compensate you ***a total of $100 per month*** if you are scheduled to work at least 30 hours a week or if you are a contract employee with full time benefits and you waive medical coverage because you have eligible coverage under other group insurance. Waiving medical coverage means that you relinquish coverage for all medical plan components, which include medical, vision, pharmacy, wellness, and behavioral health and substance abuse benefits. You may purchase the vision benefit separately if you waive your medical insurance. Refer to "Avesis Vision Option with Medical Waiver" in the "2005 Premium Rates" section. This taxable compensation will be remitted in 24 payments in the first two paychecks of each month. In no case is a payment made on the third paycheck of the month unless there is a retroactive arrears balance. You are required to provide proof of other group medical insurance coverage to qualify for the waiver payment. Election of a waiver of medical insurance may be done only during the new hire election period, within 30 days of a qualified status change (e.g., going from being scheduled to work less than 30 hours per week to 30 or more hours per week) or during open enrollment. Arizona Health Care Cost Containment System (AHCCCS) coverage does not qualify as group health insurance coverage and does not qualify you to waive your group medical benefits to be eligible for the waiver payment. Medical waiver payments stop while you are on an unpaid leave of absence (LOA) and resume when you return to active status.

DO BENEFITS CONTINUE WHILE ON A LEAVE OF ABSENCE?

When you take an approved unpaid LOA from your position, you must continue to pay your portion of the premiums for your benefits, such as medical and dental, and the full premium amount for supplemental life insurance and STD coverage in order to continue coverage. Your basic life coverage will continue in force while you are on an approved unpaid medical LOA for up to six months of premiums. If you are on active duty military leave, personal leave more than 90 days or medical leave for more than 180 days, you must port your life insurance coverage to continue coverage. If you do not want to continue some or all of your coverage, you must revoke coverage by completing a Change Form within 30 days of the beginning date of your unpaid LOA. However, your STD coverage may not be revoked. Contact the Benefits Office for a Change Form.

If you want to continue your benefits coverage, you must complete a Payment Agreement form with the Benefits Office in advance of your leave, if possible, to decide on premium payment and coverage options while you are on an approved LOA. If advance notice is not possible due to your medical condition or other extenuating circumstance, the agreement must be made within 30 calendar days of your leave beginning date to avoid coverage cancellation.

You must continue to pay your portion of the insurance premiums in a timely manner (either by pre-payment or semi-monthly) for coverage to continue. The County will not pay its portion of the premium for medical and dental coverage until your payment is received. **Non-payment or untimely payment (following a 30 day grace period) of your portion of the premium will result in coverage cancellation, effective the last day of the pay period in which you paid your portion of the premium. When coverage is terminated, you are liable and responsible for all claims incurred after your cancellation effective date**.

Note: If you are receiving STD, your payments for premiums will be deducted from your STD payments on a prorated daily basis for the period for which the STD payment is made.

As a convenience while you are on LOA, the Benefits Office will accept premium payments through Visa or MasterCard. To make your payments in this manner, please contact the Benefits Office.

Upon receipt of your portion of the monthly premiums, the County will make its contribution to medical and dental premiums for you and your dependents while you are on an approved personal LOA for up to three months of premiums ($^{6}/_{24}^{ths}$ of the annual premium) in a rolling 12-month period starting the first day of your unpaid leave.

Upon receipt of your portion of the premiums, the County will make its contribution to medical and dental premiums for you and your dependents while you are on either an approved Family Medical Leave Act (FMLA) or non-FMLA medical LOA for up to six months of premiums ($^{12}/_{24}^{ths}$ of the annual premium) in a rolling 12-month period starting the first day of your unpaid leave. County contributions toward your medical and dental premiums may not extend beyond six months in a rolling 12-month period by combining a personal leave with a medical leave. If you do not return to work after your FMLA leave entitlement has been exhausted or expires, ***in certain situations the County may recover from you*** the portion of medical and dental premiums it paid on your behalf while you were on such LOA, in accordance with federal regulations 29 CFR 825.213.

If you continue on an approved unpaid LOA beyond the point at which the County's contribution ends or if you terminate or resign employment (either voluntarily or involuntarily), you become ineligible for the County contribution to your medical and dental benefits. However, if you are included in a reduction in force (RIF), you may be eligible to continue your benefits according to the HR2403 Reduction In Force Policy. Refer to HR2403 Reduction In Force Policy for information on how benefits may be continued. Special Health Care District

employees should refer to applicable District policy.

A COBRA notice containing enrollment and premium information will be mailed to you at your address on file in the Benefits administration system if you become ineligible for County contributions toward your benefits. By enrolling in COBRA coverage within the designated period and paying the total monthly premiums and administrative charge, coverage for the elected health care benefits (medical, dental, vision and/or health care FSA) will continue retroactive to the date of ineligibility without a break through the period of COBRA eligibility.

If you do not elect to continue coverage by completing a Payment Agreement or you do not revoke your benefits by completing a Change Form within 30 days from the beginning of your unpaid LOA, and if your leave lasts for less than 90 days, the Benefits Office will assume that you want to continue your benefits and you will be liable and responsible for paying your portion of all your premiums and your FSA annual pledge while on a LOA. Upon your return to work, your unpaid premiums will be deducted from your paychecks in amounts calculated in accordance with the Benefits Office arrears procedure. Your FSA annual pledge will be recalculated to fully deduct the remaining portion of your annual pledge through the remaining pay periods in the benefit plan year. If you terminate employment and you have not paid your overdue premiums, you will be subject to collection action.

If you do not revoke your benefits by completing a Change Form within 30 days of the beginning of your unpaid leave, you do not elect to continue coverage by completing a Payment Agreement, your leave lasts more than 90 days and you have not paid your premium(s), the Benefits Office will assume that you do not want to continue your benefits and your coverage will be terminated retroactively to the end of the last pay period in which premiums were paid. **You will be liable and responsible for all claims incurred after your termination effective date**. No premiums will be due past your termination effective date. If you return to work, your FSA annual pledge will be recalculated to fully deduct the remaining portion of your annual pledge through the remaining pay periods.

Note: In any case where your premium payments are not current, the insurance carrier may interrupt and/or terminate your benefits.

If coverage is terminated because of premium non-payment or revocation of benefits during your LOA, coverage may be reinstated with no waiting period upon your return to benefit-eligible active employment status if you complete a Change Form upon your return from leave within 30 days of returning. Failure to complete a Change Form within the 30 day period will result in loss of benefits for the remainder of the plan year. Refer to the “When Can Changes Be Made?” section.

Note: You are not eligible to receive a medical waiver payment during an unpaid LOA.

Subject to and in conformance with Maricopa County’s Military Leave Policy (HR2417), USERRA and 10 U.S.C. § 1071 et. seq, employees who are members of the uniformed services have the option of obtaining medical and dental benefits for themselves and their dependents through the military health care system or may choose to continue their health and other benefits (restrictions apply to life insurance which must be ported if the leave is greater than 90 days) through **Maricopa County’s Employee Benefits Plan** for a period of one year to begin when the employee is placed on Leave Without Pay after the commencement of active duty. To continue coverage through Maricopa County’s Employee Benefits Plan, the employee must notify the Benefits Office within 30 days of the unpaid leave and make timely payments, as specified above, of his/her premiums during the period of active duty. Upon conclusion of the one year coverage period, the employee will be entitled to continue coverage through Maricopa County’s Employee Benefits Plan for an additional six months and the employee will be required to pay the entire cost of the coverage premiums for the additional six month period. The employee must complete and sign Attachment A, Employer Notification of Uniformed Service, which is located at the end of policy HR2417, available online at http://ebc.maricopa.gov/pp/hr/pdf/h2417.pdf.

WHEN DOES COVERAGE END?

Coverage ends on the day you and/or your covered dependents cease to be eligible for coverage or the last day of the pay period for which a premium was paid for an eligible participant, whichever comes first. (Refer to the “Who’s Eligible?” and “Do Benefits Continue While On A Leave of Absence?” sections.) **When coverage ends, you are liable and responsible for all claims made after your last day of coverage.**

You are responsible for immediately notifying the Benefits Office when a dependent no longer meets the eligibility requirements listed in the “Are Dependents Covered?” section, as well as completing the required enrollment Change Form within 30 calendar days of the date on which the dependent lost eligibility. Medical, other benefit expenses and administrative costs paid or incurred on behalf of an ineligible dependent become your liability and responsibility from the beginning date of ineligibility. In addition, if you delay in completing the notification and enrollment change process, you will be responsible for premiums that cannot be retroactively refunded to you.

If your covered dependent becomes ineligible for medical or dental insurance or the health care FSA and if you complete the required notification and enrollment change process within 30 calendar days of the event, a COBRA

notice containing enrollment and premium information will be mailed to the dependent at the address on file in the Benefits administration system. By enrolling in COBRA coverage and paying the monthly premium and administrative charge, coverage for the elected benefits will continue retroactive without a break in coverage and will continue through the required COBRA eligibility period.

WHEN CAN CHANGES BE MADE?

You are able to pay for your benefits with pre-tax dollars because of Maricopa County's establishment of a cafeteria plan as defined by the IRC Section 125. In return for tax-free premiums, you are limited as to when you can make benefit election changes and when those changes can be made effective.

You are not allowed to change or drop STD coverage at any time during the plan year. In addition, you will not be able to change your medical or pharmacy plan (e.g., from CIGNA HMO High Option to CIGNA POS Low Option or Coinsurance Rx to Consumer Choice Rx) during the plan year. Such changes are allowed only during the regularly scheduled open enrollment period.

If you experience a qualified status change as defined in the IRC Section 125, you may add or drop dependents or change the level of benefit coverage. Qualified status changes must be verified and must be consistent with the event as defined under IRC Section 125. For example, if an employee divorces and is enrolled in a Mariflex dependent care FSA, the employee may or may not be allowed to drop the FSA coverage because the divorce may or may not have removed the responsibility for day care expenses.

In accordance with ARS 20-1057 B, if your medical coverage is under the CIGNA HMO or the POS plan, coverage of a newborn child, a child placed for adoption or an adopted child will be effective from the date of birth or placement and will continue for the following 30 calendar days if you are the primary insured, according to Coordination of Benefits National Association of Insurance Commissioners (NAIC) rules. NAIC rules determine primary responsibility for coverage based on the earliest birthday in the year of the child's parents. No premium is associated with coverage for the first 30 days as long as you do not enroll the child for ongoing coverage. In order for medical coverage to continue past the initial 30 days, you will be required to pay a premium retroactively to the date of the event if you are not currently in the appropriate coverage premium level (e.g., if you are paying the employee-only or employee-and-spouse premium instead of employee and family or employee and child). In order to properly administer the ongoing enrollment of the newborn in the medical and/or pharmacy plan, you must notify the Benefits Office of your status change and complete the required paperwork as specified in the preceding paragraph. If you fail to submit your Change Form and documentation within the appropriate timeframe, your newborn will not be covered after the initial 30 days.

WHAT IS THE REQUIRED NOTIFICATION AND ENROLLMENT CHANGE PROCESS?

If you have a qualified status change and want to make a pre-taxed benefit election change, you must complete the required notification and enrollment process. The required process is described below.

You first must notify the Benefits Office via e-mail, written correspondence or in person. An Enrollment/Change form may be generated for your completion following your notification to the Benefits Office. The Benefits Office or your designated HR Liaison must receive the completed Enrollment/Change form (or you complete the online enrollment) and appropriate third party documentation of the change event within 30 calendar days of the event.

If you complete the hard copy Enrollment/Change form and deliver it to your department's designated HR Liaison, it is his/her responsibility to immediately deliver it to the Benefits Office. To expedite processing, you are encouraged to complete the online enrollment or deliver all required forms and documents directly to the Benefits Office. The Enrollment/Change form includes delivery instructions.

WHAT IS A QUALIFIED STATUS CHANGE?

Examples of qualified status changes as permitted by IRC Section 125 are listed below. In all cases, the election change must be consistent with the actual status change.

1. Leave under the Family Medical Leave Act (FMLA).
2. Judgment, decree or order resulting from a divorce, legal separation, annulment or change in legal custody, including a qualified medical child support order requiring accident or health coverage for an employee's child.
3. Entitlement or loss of entitlement of Medicare or Medicaid (in Arizona, the Medicaid program is the Arizona Health Care Cost Containment System, usually referred to by its acronym, AHCCCS).

4. Change in status:
    a. Events that change an employee's legal marital status, including the following: marriage; death of spouse; divorce; legal separation, or annulment.
    b. Events that change an employee's number of dependents, including the following: birth; death; adoption, and placement for adoption. In the case of the dependent care spending account, a child turning age 13.
    c. Any of the following events that change the employment status of the employee, the employee's spouse or the employee's dependent.
        - A termination or commencement of employment.
        - A strike or lockout.
        - A commencement of or return from an unpaid LOA.
        - A change in residence or work site where eligibility no longer exists for the plan originally selected.
        - A change in the number of regularly scheduled hours to become benefit eligible.
        - A change in job or employment status that renders the employee benefit eligible or ineligible, such as moving from temporary status (benefit ineligible) to a regular status benefit-eligible position or changing from a contract position with no benefits to a position with benefits.
5. Dependent satisfies or ceases to satisfy eligibility requirements such as attainment of age or change in student status.
6. Significant cost or coverage changes.

WHEN ARE QUALIFIED STATUS CHANGES EFFECTIVE?

IRC Section 125 governs the effective dates of coverage and premium changes related to qualified status changes.

ADDING DEPENDENT(S) AND/OR COVERAGE

For birth, adoption or placement for adoption, and if you completed the required notification and enrollment process within 30 calendar days of the event date, your insurance coverage and the respective premium change will be effective on the event date. Changes in FSA amounts will be effective within the pay period in which you completed the notification and enrollment process.

For all other events, you may add dependents or coverage or increase your current level of coverage if you completed the required notification and enrollment process within 30 calendar days of the event date. Your insurance coverage will be effective on the date of the event or within the pay period in which you completed the required notification and enrollment process, whichever is later. The premium changes will be effective within the pay period in which the benefits coverage becomes effective. Changes in FSA amounts will be effective within the pay period in which you completed the notification and enrollment process.

In all cases, if you elect a higher annual election for the spending accounts, the amount of your annual election increase will not be available for reimbursement for any claims incurred before the date on which the coverage change became effective.

DROPPING DEPENDENT(S) AND/OR COVERAGE

If you complete the required notification and enrollment process within 30 calendar days of the event date, your insurance coverage change will be effective on the date of the event. Any premium change will be effective within the pay period in which the coverage change was effective.

If you do not complete the required notification and enrollment process within 30 calendar days of the event date, your annual election may change only prospectively, to be effective within the pay period in which you completed the notification and enrollment process.

If you are enrolled in the spending accounts and if you did not complete the notification and enrollment process within 30 calendar days of the event, your dependent loses eligibility on the event date; however, you are not allowed to change your annual election.

In all cases, you cannot decrease your FSA annual elections to be lower than the amounts by which you have already been reimbursed.

LOSS OF ELIGIBILITY FOR EMPLOYEE BENEFITS

Should you lose eligibility for employee benefits through termination of employment or change of appointment (regular to temporary), coverage and premiums will end the last day of the pay period during which the event occurred.

HIPAA PRIVACY NOTICE

In accordance with the privacy standards contained in the Health Insurance Portability and Accountability Act (HIPAA) of 1996, Maricopa County, in its role as the administrator of your benefits plan, makes available a notice setting forth its privacy practices through the EBC/Intranet, on the Benefits Home Page, at the HIPAA link. This notice describes the potential uses and disclosures of Protected Health Information (PHI), the individual's rights and the plan's legal duties with respect to PHI. The privacy notice may be updated occasionally and such updates will be communicated through e*Nouncements, accessible through the EBC.

SHARING OF YOUR PROTECTED HEALTH INFORMATION

You and your dependents' PHI will be shared with specific benefit plan representatives and others for the purposes of your health care treatment, for payment for that treatment and for health care operations (as defined in the HIPAA of 1996, as amended) of Maricopa County and of the benefit plan vendors, as well as for other purposes allowed or required by law. When you submit your enrollment application, make an open enrollment or qualified status change or continue with your current coverage, you are acknowledging and accepting that Maricopa County and your health care providers, which could include CIGNA, HealthSelect, Walgreens Health Initiatives (WHI), United Behavioral Health (UBH), United Concordia, EDS, UNUMProvident, VPA, Inc., Avesis, Application Software Inc. (the FSA administrator), ComPsych Guidance Resources (the Employee Assistance Plan administrator) and WHI in its role as pharmacy benefits manager, may share medical and administrative information concerning you and your dependents. By participating in the benefit plan, you are releasing Maricopa County and Maricopa County's health care providers from any liability for any good faith release of protected health information pursuant to this acknowledgement.

NOTICE REGARDING USE OF YOUR SOCIAL SECURITY NUMBER

Disclosure of your Social Security Number (SSN) for purposes of enrollment and other benefit-related uses is voluntary. Identification (ID) cards from all vendors will carry no ID number, an edited ID number (revealing only the last four digits of your SSN), your employee ID number or a randomly system-generated number. Your SSN is transmitted to the benefit plan vendors for administrative purposes. Some vendors will use your SSN as your ID number or cross-reference their assigned ID number to your SSN. If you do not want your SSN transmitted to the benefit plan vendors, you may request an alternative ID number. If you are participating in Mariflex, the vendor must have access to your SSN to report your FSA to the Internal Revenue Service (IRS).

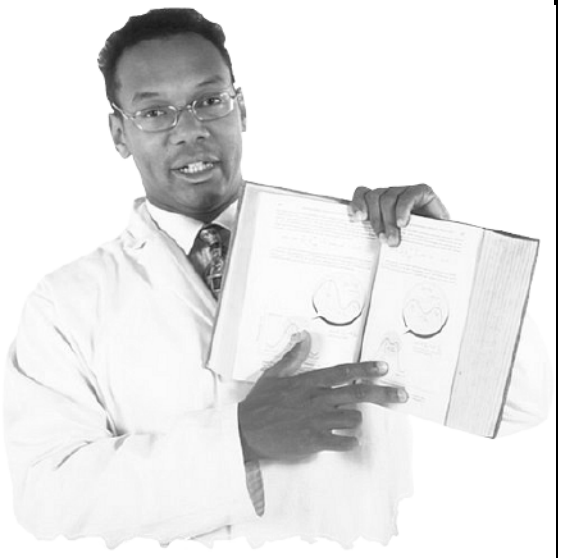
ALTERNATIVE ID NUMBER

You may request an alternative ID number at any time by sending your request in writing to the Benefits Office. You will be provided with a form to complete before the alternative number will be assigned. This will delay your enrollment (but not your coverage begin date) in benefits until the alternative number is assigned. The Benefits Office will provide your alternative ID number to your medical, prescription, vision, behavioral health and dental vendors. United Concordia, one of the dental plan providers, may assign its members a different alternative ID number. Once the vendor assigns an alternative ID number, you and your dependents will not be identifiable by your SSN. Assignment of an alternative ID number may become a temporary barrier to receiving medical services or to having your medical claims correctly paid. You are responsible for advising each provider that you have an alternative ID number. If the vendor uses a system-generated ID number, your alternative ID number will be cross-referenced to the system-generated ID number. When you access services, your provider will verify your current eligibility by calling the vendor. The provider must use either your current alternative ID number or your system-generated ID number so that your eligibility can be established, you can access services and your claims can be processed and paid. Additionally, when an alternative ID number is assigned, if you have ever been identified by your SSN, some vendors do not have the technology to cross-reference your records to re-establish prior authorizations or referrals for your care or to process claims submitted under your SSN as the key link between you and their records (your SSN) has been broken. This may cause a temporary delay in receipt of services or result in denied claims until you notify the vendor to correct the records.

MEDICAL PLANS: HealthSelect

- ***HEALTHSELECT* – *A MANAGED CARE PRODUCT SPONSORED BY MARICOPA COUNTY AND ADMINISTERED BY CIGNA***

GROUP NUMBER: 3310592



HealthSelect offers two different medical plans: HealthSelect High Option and HealthSelect Low Option. The High Option plan has a higher premium but lower copayments for services. The Low Option plan has a lower premium but higher copayments for services.

All care is directed through a primary care physician (PCP) — family practice, pediatrician, internist or, during pregnancy, an obstetrician/gynecologist (OB/GYN) — who practices in one of 11 Family Health Care (FHC) facilities or in a private practice office. Your PCP delivers your primary care and coordinates your specialty care through referrals. Urgent care is provided by your PCP from 8 a.m. to 5 p.m. Monday through Friday. If your PCP is unable to see you and your medical need is urgent, you can receive care at one of the FHCs with extended hours or at contracted urgent care facilities. Referrals are not required to see a contracted OB/GYN or for urgent care, emergency care, chiropractic care or alternative medicine services. Certain services require prior authorization. Members must receive all non-emergency care from HealthSelect's network providers, including physicians, hospitals, and/or ancillary providers within the medical delivery service area of Maricopa County. There is no out-of-network coverage except that members are covered for emergency care anywhere in the world.

Refer to the "HealthSelect Benefits at a Glance" chart at the end of this section for summary information or to the HealthSelect Summary Plan Document for specific information. You choose your pharmacy benefit separately from your medical plan. Refer to the "Pharmacy Benefits for All Medical Plans" section to review your choices.

PHYSICIAN AND HOSPITAL NETWORK

A network of more than 350 physicians in FHCs and private physician offices throughout Maricopa County offers you a variety of provider choices. HealthSelect contracts with 15 hospitals in Maricopa County. Eleven FHCs offer comprehensive health care, and many have in-house pharmacies for your convenience. Several FHCs offer extended hours on weekdays and on Saturdays. These locations are in the East, West and Central Valley and include the Chandler FHC, the Seventh Avenue FHC and the Glendale FHC. For a list of practitioners participating in the HealthSelect network, access the provider directory through the Benefits Home Page, pick up a directory at the Benefits Office or visit http://www.maricopa.gov/medcenter/healthplans/providerlist. You also can call CIGNA's customer service department at 1-800-244-6224 to ask whether a specific provider participates in HealthSelect network AZ904.

WELLNESS INCENTIVES

Family wellness is a major focus of the HealthSelect plan. Therefore, maintaining your good health makes you eligible to receive wellness incentives from the plan, including:

- **Health club (workout) incentive.** A $75 gift card every six months for active use of a health club. You must provide proof in the form of a certificate on which health club staff has noted your completion of eight workouts a month for a continuous six-month period.
- **Health screenings.** A $30 gift card for completion of mammograms for women over age 40; pap smear tests for women 18 and older; and physical exams for men 40 and over.
- **Children's immunizations.** A $30 gift card for up-to-date childhood immunizations for children up to 2 years.
- **Smoking cessation class, diabetic education program or other health education program.** A $30 gift card for successful completion of a health education or smoking cessation class.

THE HEALTHSELECT MEDICAL PLAN INCLUDES THE FOLLOWING BENEFITS

Alternative Medicine

Twelve self-referred alternative medicine visits per year are covered, with a copayment of $5 per visit. A credit of $60 for herbal/homeopathic or natural supplements prescribed by the alternative medicine provider is also offered. Providers in the designated HealthSelect alternative medicine network must be used when accessing this benefit. Members must send a copy of the doctor's order/prescription along with the paid receipt for the item(s) to the Benefits Office to be reimbursed.

The alternative medicine benefit includes:

- Acupuncture
- Homeopathy
- Osteopathic Manipulation, and
- Craniosacral Therapy

Behavioral Health and Substance Abuse Benefit

Provided by United Behavioral Health. See the "Behavioral Health and Substance Abuse Services" section of this booklet for details.

Vision Benefit

Provided by Avesis. See the "Vision" section of this booklet for benefit details.

ADDITIONAL BENEFITS

- **24 hour worldwide emergency care**
- **24-Hour Health Information Line**SM – Provides access to health information from registered nurses (RNs) at any time. When you are not sure where to go to seek non-emergency care, you can call and speak with a nurse who can respond to your health care questions, direct you to the nearest participating medical facilities or provide suggestions for helpful home care that may comfort you until you see your doctor. Call 1-800-564-8982. You also have access to the Health Information Library where you can listen to taped programs on hundreds of topics.
- **Wellness programs** – The *Well Aware Program for Better Health* is an integrated disease management program that helps members manage asthma, low back pain, cardiovascular disease and diabetes, and is available by calling 1-800-249-6512; and *Healthy Babies*, a program for prenatal guidance, is available by calling 1-800-244-6224.
- **CIGNA *Healthy Rewards* Program** – Provides discounts on alternative health services and health and wellness products including fitness club memberships, chiropractic services, therapeutic massage, acupuncture, cosmetic dentistry, laser vision correction, vitamins and herbal supplements, hearing aids and tests. Call 1-800-870-3470 for more information or go online to www.cigna.com/healthyrewards.
- **myCigna.com** - Access your benefit and claim information, request an ID card, view participating providers, change your PCP and more through this online Web site.
- Reimbursement of up to $125 per semester towards the premium for student health insurance for out-of-area students.
- $500 hearing aid allowance.

This is a brief summary of your benefits. For more information regarding your HealthSelect medical plan, claims payments or to find a participating provider (in the AZ904 network), contact the HealthSelect Customer Service Department 8 a.m.-6 p.m. MST Monday through Friday at 800-244-6224 or online at www.cigna.com or www.mycigna.com 24 hours a day. When calling the CIGNA Customer Service Department, identify yourself as a HealthSelect member in network AZ904.

CIGNA processes medical claims, which should be mailed to: CIGNA, PO Box 182223, Chattanooga, TN 37422-7223.

For details about the HealthSelect medical plan, you may refer to the HealthSelect Summary Plan Document on the Internet Web site at www.maricopa.gov/benefits or on the EBC/Intranet at ebc.maricopa.gov/hr/benefits.

HEALTHSELECT BENEFITS AT A GLANCE

STANDARD BENEFIT COVERAGE	High Option	Low Option
Deductible		
Individual	None	None
Family	None	None
Standard Coinsurance % Covered by Plan	None	None
Out-of-Pocket Maximum (OOP)		
Individual	None	$5,000 OOP Maximum for inpatient & outpatient facility copay
Family	None	$10,000 OOP Maximum for inpatient & outpatient facility copay
Lifetime Maximum Benefit	None	None
Pre-existing Condition Limitation	None	None
GENERAL SERVICES		
Primary Care Physician Services	$10 Copay	$25 Copay
Specialty Care Physician Services	$10 Copay	$45 Copay
Independent Lab & X-Ray Facility	No Copay for lab or x-ray; $25 Copay for MRI, MRA, PET & CT Scans	No Copay for lab or x-ray; $100 Copay for MRI, MRA, PET & CT Scans
Outpatient Surgery	No Copay	$250 Copay, then covered at 90%
Urgent Care Facility (Participating)	$25 Copay if urgent, otherwise not covered	$50 Copay if urgent, otherwise not covered
Emergency Room (Copay Waived if Admitted)	$50 Copay if emergency, otherwise not covered	$100 Copay if emergency, otherwise not covered
Ambulance	No Copay if emergency, otherwise not covered	No Copay if emergency, otherwise not covered
INPATIENT HOSPITALIZATION		
Facility Services	No Copay	$500/admission, then covered at 90%
Physician & Surgeon's Services	No Copay	No Copay
Penalty for Not Getting Prior Authorization	None	None
MATERNITY		
Prenatal & Postnatal Exams	$10 Copay waived after 1st visit	$45 Copay waived after 1st visit
Hospital Delivery	No Copay	$500/delivery; then covered at 90%
EQUIPMENT & DEVICES		
Durable Medical Equipment	No Copay ($2,000 maximum)	No Copay ($3,500 maximum)
External Prosthetics & Orthotics	No Copay ($2,000 maximum)	$200 deductible ($1,000 maximum)
OUTPATIENT REHABILITATION		
Physical, Speech, & Occupational Therapy	$10 Copay; 60 visits combined maximum/year	$45 Copay; 60 visits combined maximum/year
Chiropractic Services (chronic conditions not covered; must be medically necessary).	$10 Copay 12 self-referral visits/year	$45 Copay; 20 self-referral visits/year
Alternative Medicine; uses designated network	$5 Copay; 12 Self-referral visits/year $60 credit for supplies/products	$5 Copay; 12 Self-referral visits/year $60 credit for supplies/products
OTHER HEALTHCARE FACILITIES		
Skilled Nursing Facilities		
Subscriber Payment	No Copay	Covered at 90%
Limit per Contract Year	60 days per year	60 days per year
Home Health Care	No Copay when medically necessary (unlimited)	No Copay when medically necessary (unlimited)
FAMILY PLANNING		
Sterilization		
Vasectomy	Place of Service Copay	Place of Service Copay
Tubal Ligation	Place of Service Copay	Place of Service Copay
Infertility Services	Place of Service Copay; Diagnostic Services & Corrective Treatment Only	Place of Service Copay; Diagnostic Services & Corrective Treatment Only

MEDICAL PLANS: CIGNA

• *CIGNA – PROVIDED BY CIGNA HEALTHCARE OF ARIZONA*

CIGNA offers six different medical plans with cost variances based on the amount of freedom you have to use the health care delivery system. The six available plans include a Health Maintenance Organization (HMO) High Option and Low Option, Point-of-Service (POS) High Option and Low Option and Preferred Provider Organization (PPO) High Option and Low Option. The Low Option PPO plan meets the requirement as a high-deductible health plan, allowing you to purchase a Health Savings Account.

The high option plans have a higher premium but lower copayments for services. The low option plans have a lower premium but higher copayments for services. Refer to the CIGNA benefits at a glance charts at the end of this section for summary information or to the CIGNA Group Service Agreement (GSA)/Plan Certificate for specific information. Your pharmacy benefit is chosen separately from your medical plan. Refer to the "Pharmacy Benefit Plan for All Medical Plans" section to review your choices.

CIGNA HMO - A HEALTH MAINTENANCE ORGANIZATION (USING THE CIGNA MEDICAL GROUP CLINICS AS THE HEALTH CARE DELIVERY SYSTEM)

GROUP NUMBER: 3205496

The CIGNA HMO plan offers quality health care at an affordable cost. In order to enroll in this plan, you must reside or work in Maricopa County.

There are no pre-existing limitations or deductibles with this plan. The HMO plan has an annual out-of-pocket (OOP) maximum for your protection. Only inpatient and outpatient facility copayments apply to the OOP maximum.

The HMO plan is a Primary Care Physician (PCP)-based plan requiring you and each dependent to choose a PCP (family practice, pediatrician or internist) who practices in one of the 17 CIGNA Medical Group (CMG) clinics. The CMG clinics are facilities where several physicians employed by CIGNA are located. Your PCP will deliver your primary care at one of the CMG clinics and coordinate your specialty care through referrals to contracted providers in the HMO network. Referrals are not required to access an OB/GYN within a CMG clinic, or to access urgent care, emergency care, chiropractic care and/or alternative medicine services. Some specialty care will also be provided within the CMG clinics.

You must receive all non-emergency care through the HMO network, which is located within the service area of Maricopa County. This includes physicians (PCPs and certain specialists at a CMG clinic or specialists in private office settings by PCP referral), hospitals and/or ancillary providers. There is no out-of-network coverage for non-emergency care under this plan. However, you are covered for emergency care anywhere in the world.

Certain services, such as inpatient hospitalizations, require pre-certification, and such certification is obtained by your CIGNA HMO provider.

Your selected PCP must be contracted with the CMG network AZ812. Please use the provider directory titled The Many Faces of CIGNA Medical Group. Or go online to www.mycigna.com or www.cigna.com. From the home page, select the Provider Directory link, enter your physician search requirements and on the next page, under the "Select your benefit plan or program" option, choose "Network (HMO) Plans **or Point of Service (POS) Plans**." From the "If you chose the Network and Point of Service Plans above" drop-down list, select AZ-CIGNA Medical Group, and continue with the prompts. You can also call CIGNA's customer service department at 1-800-244-6224 and ask if a provider participates in network AZ812.

Physicians who practice in their private offices outside the CMG clinics are not included in this plan. If you wish to see physicians who practice in their private offices, you should select the POS or the PPO plan.

CIGNA HMO CMG Plan Highlights

- 17 convenient medical group (health care) clinics from which to access care
- Alternative medicine benefits
- 20 self-referred chiropractic visits to participating providers

CIGNA POS - A POINT-OF-SERVICE PRODUCT

GROUP NUMBER: 3205496

The POS plan offers quality health care at a slightly higher cost than the HMO plan. The POS plan offers services within CIGNA's large POS network, along with the option of going out-of-network for most services at the point of service. The POS plan gives you maximum savings when using in-network providers, and offers the flexibility and freedom of going outside the network as you wish. You must reside or work in Arizona to enroll in this plan. Whether using in-network or out-of-network benefits, the plan features an out-of-pocket (OOP) maximum for your financial protection. Only inpatient and outpatient facility copayments count toward the OOP maximum. Inpatient and outpatient facility deductibles, along with coinsurance for all benefits, also count toward the OOP maximums. Expenses that do not count toward the OOP maximums include the deductible (except for inpatient and outpatient facility deductibles); the excess amount above that which is reasonable and customary (R&C); non-compliance penalties, and copayment amounts. No deductibles or pre-existing limitations apply when using in-network benefits.

When using out-of-network benefits, deductibles apply unless a copayment is charged for the benefit. Copayments do not count toward the deductible. Pre-existing limitations apply to out-of-network benefits.

POS IN-NETWORK

When you use your in-network benefits, the POS plan operates as a PCP-based plan in which you and each dependent must choose a PCP. Your PCP (family practice, pediatrician or internist) will deliver your primary care and coordinate your specialty care through referrals for all care except OB/GYN, urgent care, emergency care, chiropractic care and alternative medicine services.

You must receive all non-emergency care through the POS private practice network within the state of Arizona. This includes physicians, hospitals and/or ancillary providers. However, you are covered for emergency care anywhere in the world. Certain services, such as inpatient hospitalizations, require pre-certification, and such certification is obtained by your CIGNA POS provider.

Your selected PCP must be contracted with the CIGNA Healthcare of Arizona network AZ801 (also referred to as the private practice network). Please use the provider directory titled CIGNA Healthcare of Arizona. Or go online to www.mycigna.com or www.cigna.com. From the home page, select the Provider Directory link, enter your physician search requirements and click the "Continue" button. From the next page, select your benefit plan or program and from the "If you chose the Network and Point of Service Plans above" drop-down list, select the AZ-Arizona option. Then continue with the prompts. You can also call CIGNA's customer service department at 1-800-244-6224 and ask if a specific provider is participating in network AZ801.

The POS network contains the CIGNA HMO providers who practice in the CMG clinics, plus a wide selection of doctors in private office settings. The POS plan has a larger hospital network than the HMO plan but not quite as large as the PPO network.

POS OUT-OF-NETWORK

By using **out-of-network** benefits, you can see any doctor or practitioner, or use any facility of your choice without a referral, when it is not contracted with CIGNA's POS network. Using these out-of-network benefits also enables you to see a doctor in CIGNA's POS private practice network from whom you have no referral. However, not all benefits are covered out-of-network. Before using certain services requiring pre-certification, you must obtain approval through CIGNA.

The plan will reimburse your claims at 70 percent of the R&C amount as defined by CIGNA (except where copayments apply) after meeting your calendar year deductible. If the provider charges a higher amount, you will be responsible for the excess charges (the difference between billed charges and R&C amounts). You may have to pay for services received and file a claim for reimbursement if the out-of-network provider will not file the claim for you.

CIGNA POS Plan Highlights

- In- and out-of-network coverage
- Alternative medicine benefit
- 20 self-referred chiropractic visits to participating providers

CIGNA PPO - A PREFERRED PROVIDER ORGANIZATION PRODUCT

GROUP NUMBER: 3205496

The PPO plan requires no referrals to access services. Both in-network and out-of-network coverage are available with this plan, which offers the largest provider network with the highest degree of flexibility and freedom of choice.

Most benefits are subject to deductibles and coinsurance and, for your financial protection, have an out-of-pocket (OOP) maximum. Coinsurance and deductibles (for the low option plan) apply to the OOP maximum. Non-compliance penalties, deductibles (for the high option plan), copays or charges in excess of R&C do not count toward the OOP maximum. Copayments do not count toward the deductible.

Pre-existing limitations apply to both in-network and out-of-network services. See the "Pre-Existing Limitation" section below.

There are no residency requirements associated with enrollment in this plan.

PPO IN-NETWORK

In-network medical care is accessed directly by the employee and/or family member(s) through participating physicians, practitioners and/or facilities without referrals. You are not required to select a PCP and you can see any participating provider you choose, including specialists.

Certain services require pre-certification, and your contracted practitioner is responsible for obtaining approval through CIGNA before these services are provided.

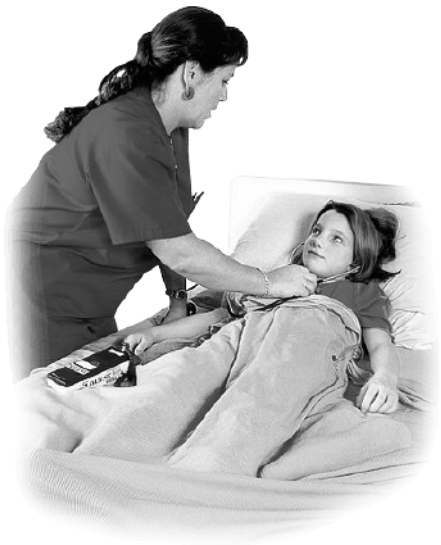
As a PPO participant, you will have lower OOP expenses when you receive care **in-network** from participating CIGNA physicians in the PPO national network. To see a list of practitioners and hospitals participating in the CIGNA PPO network, use the provider directory titled Preferred Provider Network PPO/PPA. Or go online to www.mycigna.com or www.cigna.com and select the Provider Directory link from the home page, enter your physician search requirements and then click the "Continue" button. From the next page, beneath "Select your benefit plan or program", choose the option "Preferred Provider Organization (PPO)" and continue with the prompts. You can also call CIGNA's customer service department at 1-800-244-6224 and ask if a provider is participating in the PPO national network.

PPO OUT-OF-NETWORK

When using **out-of-network** benefits, you use non-participating doctors for care, but your benefit coverage is reduced, resulting in higher OOP costs. Not all benefits are available out-of-network.

Certain services require pre-certification, as explained in the GSA/Plan Certificate. You are responsible for obtaining pre-certification approval through CIGNA before using such services.

The plan will reimburse your claim at a CIGNA-defined percentage of the R&C amount after you meet your calendar year deductible. If the provider charges a higher amount, you will be responsible for the excess charges (the difference between billed charges and R&C amount). You will have to pay for services received and thereafter file a claim for reimbursement.



CIGNA PPO Plan Highlights

- In- and out-of-network coverage
- No PCP or referral requirements
- Alternative medicine benefit
- Unlimited medically necessary chiropractic visits

PRE-EXISTING LIMITATION

A pre-existing condition is any illness or injury that is diagnosed or treated during a 90-day period immediately before your effective date of coverage under this plan. Pregnancy and genetic information with no related treatment are not considered pre-existing conditions. A child who is covered within 30 days of date of birth, adoption or placement for adoption is not subject to the pre-existing limitation.

Covered expenses will not include, and no payment will be made for, charges incurred for or in connection with a pre-existing injury or sickness, unless such pre-existing condition is incurred after a continuous one-year period during which a person is satisfying a waiting period and/or is insured for these benefits.

Under HIPAA, you will receive credit toward the pre-existing waiting period for any group health care coverage you had. You must provide, from your previous employer or insurance carrier, a certificate of creditable coverage verifying no more than a 63-day period between termination of your prior health coverage and coverage with the County.

ALL CIGNA MEDICAL PRODUCTS INCLUDE THE FOLLOWING BENEFITS

Alternative Medicine Benefit

Ten self-referred alternative medicine visits per year are covered, with a copayment of $5 per visit, and a credit of $60 for herbal/homeopathic or natural supplies as dispensed in conjunction with an office visit at a designated alternative medicine center. Providers in CIGNA's designated alternative medicine network must be used when accessing this benefit. This benefit is not available when using POS or PPO out-of-network benefits.

Covered services are:

- Physician evaluation and management
- Physical medicine
- Acupuncture/acupressure
- Massage therapy
- Homeopathic consultation
- Biofeedback/guided imagery

Behavioral Health Benefit

Provided by United Behavioral Health except for PPO Low Option plan which is provided by CIGNA Behavioral Health. Refer to the "Behavioral Health and Substance Abuse Services" section of this booklet for benefit details.

Vision Benefit

Provided by Avesis. See the "Vision Benefit Plan" section of this booklet for benefit details.

ADDITIONAL BENEFITS AVAILABLE WITH ALL CIGNA MEDICAL PRODUCTS

- **24 hour worldwide emergency care**
- **24-Hour Health Information Line**SM - Provides access to health information from RNs at any time. When you are not sure where to go to seek non-emergency care, you can call and speak with a nurse who can respond to your health care questions, direct you to the nearest participating medical facilities or provide suggestions for helpful home care that may comfort you until you see your doctor. Call 1-800-564-8982. You also have access to the Health Information Library where you can listen to taped programs on hundreds of topics.
- ***Wellness Programs -*** *Well Aware for Better Health* is an integrated disease management program helping members manage asthma, low back pain, cardiovascular disease, diabetes and chronic obstructive pulmonary disease. It is available to CIGNA HMO and POS members by calling 1-800-249-6512 and to PPO members by calling 1-877-888-3091. *Healthy Babies* is a program for prenatal guidance, available by calling 1-800-244-6224.
- ***Healthy Rewards*** **Program** - Discounts on alternative health services and health and wellness products such as fitness club memberships, chiropractic services, therapeutic massage, acupuncture, cosmetic dentistry, laser vision correction, vitamins and herbal supplements, and hearing aids and tests. Call 1-800-870-3470 to find out more information or go online to www.cigna.com/healthyrewards.
- **myCigna.com** - Access your benefit and claim information, request an ID card, view your provider directory, change your PCP and more through this online Web site.
- ***Guesting Privileges*** - Provides access to in-network benefits while you (or your dependent) are temporarily absent from the service area. Call the CIGNA Customer Service Department to determine whether you or your dependent qualifies to participate. Certain restrictions apply.

This is a brief summary of your benefits. For more information regarding your CIGNA medical care plan, claims payments or to find a participating provider, contact the CIGNA Customer Service Department 8 a.m.-6 p.m. MST Monday through Friday, at 1-800-244-6224, or online by going to www.cigna.com or www.mycigna.com 24 hours a day. When calling the CIGNA Customer Service Department, identify yourself as a Maricopa County employee.

CIGNA processes HMO and POS medical claims, which should be mailed to: CIGNA, PO Box 182223, Chattanooga, TN 37422-7223. PPO medical claims should be mailed to: CIGNA, PO Box 188039, Chattanooga, TN 37422-8039.

For additional details about the CIGNA medical plan, you may refer to the appropriate CIGNA GSA/Plan Certificate on the Internet Web site at www.maricopa.gov/benefits or on the EBC/Intranet at ebc.maricopa.gov/hr/benefits.

CIGNA HMO BENEFITS AT A GLANCE

STANDARD BENEFIT COVERAGE	High Option	Low Option
Deductible		
Individual	None	None
Family	None	None
Standard Coinsurance % Covered by Plan	None	None
Out-of-Pocket Maximum (OOP)		
Individual	None	$5,000 OOP Maximum for inpatient & outpatient facility copay
Family	None	$10,000 OOP Maximum for inpatient & outpatient facility copay
Lifetime Maximum Benefit	None	None
Pre-existing Condition Limitation	None	None
GENERAL SERVICES		
Primary Care Physician Services	$10 Copay	$25 Copay
Specialty Care Physician Services	$10 Copay	$45 Copay
Independent Lab & X-Ray Facility	No Copay for lab or x-ray, $50 Copay for MRI, MRA, PET & CT Scans	No Copay for lab or x-ray; $100 Copay for MRI, MRA, PET & CT Scans
Outpatient Surgery	No Copay	$250 Copay, then covered at 90%
Urgent Care Facility (Participating)	$35 Copay if urgent, otherwise not covered	$50 Copay if urgent, otherwise not covered
Emergency Room (Copay Waived if Admitted)	$75 Copay if emergency, otherwise not covered	$100 Copay if emergency, otherwise not covered
Ambulance	No Copay if emergency, otherwise not covered	No Copay if emergency, otherwise not covered
INPATIENT HOSPITALIZATION		
Facility Services	No Copay	$500/admission, then covered at 90%
Physician & Surgeon's Services	No Copay	No Copay
Penalty for Not Getting Prior Authorization	None	None
MATERNITY		
Prenatal & Postnatal Exams	$10 Copay waived after 1st visit	$45 Copay waived after 1st visit
Hospital Delivery	No Copay	$500/delivery; then covered at 90%
EQUIPMENT & DEVICES		
Durable Medical Equipment	No Copay ($3,500 maximum)	No Copay ($3,500 maximum)
External Prosthetics & Orthotics	No Copay ($3,000 maximum)	$200 deductible ($1,000 maximum)
OUTPATIENT REHABILITATION		
Physical, Speech, & Occupational Therapy	$10 Copay; 60 visits combined maximum/year	$45 Copay; 60 visits combined maximum/year
Chiropractic Services (chronic conditions not covered; must be medically necessary).	$10 Copay 20 self-referral visits/year	$45 Copay; 20 self-referral visits/year
Alternative Medicine; uses designated network	$5 Copay; 10 Self-referral visits/year $60 credit for supplies/products	$5 Copay; 10 Self-referral visits/year $60 credit for supplies/products
OTHER HEALTHCARE FACILITIES		
Skilled Nursing Facilities		
Subscriber Payment	No Copay	Covered at 90%
Limit per Contract Year	90 days/year combined SNF, Rehab Hospital & Sub-acute	90 days/year combined SNF, Rehab Hospital & Sub-acute
Home Health Care	No Copay when medically necessary (unlimited)	No Copay when medically necessary (unlimited)
FAMILY PLANNING		
Sterilization		
Vasectomy	Place of Service Copay	Place of Service Copay
Tubal Ligation	Place of Service Copay	Place of Service Copay
Infertility Services	Place of Service Copay; Diagnostic Services & Corrective Treatment Only	Place of Service Copay; Diagnostic Services & Corrective Treatment Only

CIGNA POS BENEFITS AT A GLANCE

	In-Network Services	Out-of-Network Services	In-Network Services	Out-of-Network Services
STANDARD BENEFIT COVERAGE	**High Option**	**High Option**	**Low Option**	**Low Option**
Deductible				
Individual	None	$300	None	$1,000
Family	None	$600	None	$2,000
Standard Coinsurance % Covered by Plan	None	70% of Reasonable & Customary Charges	None	70% of Reasonable & Customary Charges
Out-of-Pocket Maximum (OOP)				
Individual	$900 OOP Maximum for inpatient & outpatient facility copays	$3,000 OOP Maximum for inpatient & outpatient facility deductibles	$5,000 OOP Maximum for inpatient & outpatient facility copays	$10,000 OOP Maximum for inpatient & outpatient facility deductibles
Family	$1,800 OOP Maximum for inpatient & outpatient facility copays	$6,000 OOP Maximum for inpatient & outpatient facility deductibles	$10,000 OOP Maximum for inpatient & outpatient facility copays	$20,000 OOP Maximum for inpatient & outpatient facility deductibles
Lifetime Maximum Benefit	None	$5 Million	None	$1 Million
Pre-existing Condition Limitation	None	12 months waiting period; creditable coverage months may decrease the period	None	12 months waiting period; creditable coverage months may decrease the period
GENERAL SERVICES				
Primary Care Physician Services	$15 Copay	70% after deductible; preventive care covered in-network only	$35 Copay	70% after deductible; preventive care covered in-network only
Specialty Care Physician Services	$25 Copay	70% after deductible; preventive care covered in-network only	$50 Copay	70% after deductible; preventive care covered in-network only
Independent Lab and X-Ray Facility	No Copay for lab or x-ray; $50 Copay for MRI, MRA, PET & CT Scans	70% after deductible	No Copay for lab or x-ray $200 Copay for MRI, MRA, PET & CT Scans	70% after deductible
Outpatient Surgery	$100 Copay	70% after deductible	$500 Copay, then covered at 90%	$1,000/visit deductible & plan deductible, then covered at 70%
Urgent Care Facility	$50 Copay if urgent, otherwise OON at 70% after deductible	$50 Copay if urgent, otherwise 70% after deductible	$75 Copay if urgent, otherwise OON at 70% after deductible	$75 Copay if urgent, otherwise 70% after deductible
Emergency Room (Copay Waived if Admitted)	$100 Copay if emergency, otherwise OON at 70% after deductible	$100 Copay if emergency, otherwise 70% after deductible	$150 Copay if emergency, otherwise OON at 70% after deductible	$150 Copay if emergency, otherwise 70% after deductible
Ambulance	No Copay if emergency, otherwise OON at 70% after deductible	No Copay if emergency, otherwise 70% after deductible	No Copay if emergency, otherwise OON at 70% after deductible	No Copay if emergency, otherwise 70% after deductible
INPATIENT HOSPITALIZATION				
Facility Services	$100/day, $300 maximum/admission	70% after deductible	$1,000/admission, then covered at 90%	$2,000/admission deductible plus plan deductible, then covered at 70%
Physician & Surgeon's Services	No Copay	70% after deductible	No Copay	70% after deductible

CIGNA POS BENEFITS AT A GLANCE (CONTINUED)

	In-Network Services	Out-of-Network Services	In-Network Services	Out-of-Network Services
STANDARD BENEFIT COVERAGE	**High Option**	**High Option**	**Low Option**	**Low Option**
Penalty for Not Getting Prior Authorization	None	50% penalty applied to hospital inpatient charges; benefits denied for outpatient services	None	50% penalty applied to hospital inpatient charges; benefits denied for outpatient services
MATERNITY				
Prenatal & Postnatal Exams	$25 Copay waived after 1st visit	70% after deductible	$50 Copay waived after 1st visit	70% after deductible
Hospital Delivery	$100/day, $300 maximum/admission	70% after deductible	$1,000/delivery, then covered at 90%	$2,000 deductible and plan deductible, then covered at 70%
EQUIPMENT & DEVICES				
Durable Medical Equipment	No Copay ($3,500 maximum)	Covered in-network only	No Copay ($3,500 maximum)	Covered in-network only
External Prosthetics & Orthotics	No Copay ($3,000 maximum)	Covered in-network only	$200 deductible ($1,000 maximum)	Covered in-network only
OUTPATIENT REHABILITATION				
Physical, Speech, & Occupational Therapy	$15 Copay; 60 visits combined maximum/year	70% after deductible; 60 visits combined maximum/year	$50 Copay; 60 visits combined maximum/year	70% after deductible; 60 visits combined maximum/year
Chiropractic Services (chronic conditions not covered; must be medically necessary).	$15 Copay 20 self-referral visits/year	Covered in-network only	$50 Copay 20 self-referral visits/year	Covered in-network only
Alternative Medicine; uses designated network	$5 Copay; 10 Self-referral visits/year $60 credit for supplies	Covered in-network only	$5 Copay; 10 Self-referral visits/year $60 credit for supplies	Covered in-network only
OTHER HEALTHCARE FACILITIES				
Skilled Nursing Facilities				
Subscriber Payment	No Copay	70% after deductible	90% coinsurance after deductible	70% after deductible
Limit per Contract Year	90 days/year	90 days/year combined SNF, Rehab Hospital & Sub-acute	90 days/year combined SNF, Rehab Hospital & Sub-acute	90 days/year combined SNF, Rehab Hospital & Sub-acute
Home Health Care	No Copay when medically necessary (unlimited)	70% after deductible; 40 days/year	No Copay when medically necessary (unlimited)	70% after deductible; 40 days per year
FAMILY PLANNING				
Sterilization				
Vasectomy	Place of Service Copay	70% after deductible	Place of Service Copay	70% after deductible
Tubal Ligation	Place of Service Copay	70% after deductible	Place of Service Copay	70% after deductible
Infertility Services	Place of Service Copay; Diagnostic Services & Corrective Treatment Only; 50% of physician's services	Covered in-network only	Place of Service Copay; Diagnostic Services & Corrective Treatment Only, 50% of physician'	Covered in-network only

CIGNA PPO BENEFITS AT A GLANCE

	In-Network Services	Out-of-Network Services	In-Network Services	Out-of-Network Services
STANDARD BENEFIT COVERAGE	**High Option**	**High Option**	**Low Option**	**Low Option**
Deductible				
Individual	$250	$750	$1,100	$1,100
Family	$500	$1,500	$2,200	$2,200
Standard Coinsurance % Covered by Plan	80% of contracted rate	60% of Reasonable & Customary Charges	80% of contract rate	60% of Reasonable & Customary Charges
Out-of-Pocket Maximum (OOP)				
Individual	$2,000 OOP Maximum applies to coinsurance	$4,000 OOP Maximum applies to coinsurance	$5,000 OOP Maximum applies to coinsurance	$5,000 OOP Maximum applies to coinsurance
Family	$6,000 OOP Maximum applies to coinsurance	$12,000 OOP Maximum applies to coinsurance	$10,000 OOP Maximum applies to coinsurance	$10,000 OOP Maximum applies to coinsurance
Lifetime Maximum Benefit	None	$5 Million	$5 Million	$5 Million
Pre-existing Condition Limitation	12 months waiting period; creditable coverage months may decrease the period	12 months waiting period; creditable coverage months may decrease the period	12 months waiting period; creditable coverage months may decrease the period	12 months waiting period; creditable coverage months may decrease the period
GENERAL SERVICES				
Primary Care Physician Services	80% after deductible	60% after deductible; preventive care covered in-network only	80% after deductible	60% after deductible; preventive care covered in-network only
Specialty Care Physician Services	80% after deductible	60% after deductible; preventive care covered in-network only	80% after deductible	60% after deductible; preventive care covered in-network only
Independent Lab and X-Ray Facility	80% after deductible	60% after deductible	80% after deductible	60% after deductible
Outpatient Surgery	80% after deductible	60% after deductible	80% after deductible	60% after deductible
Urgent Care Facility	$50 Copay; deductible waived	$50 copay if urgent, deductible waived, otherwise 60% after deductible	80% after deductible	80% after deductible if urgent, otherwise 60%
Emergency Room (Copay Waived if Admitted)	$100 Copay; deductible waived	$100 Copay if emergency, deductible waived, otherwise 60% after deductible	80% after deductible	80% after deductible if emergency, otherwise 60%
Ambulance	90% after deductible	90% after deductible if emergency, otherwise 60% after deductible	80% after deductible	80% after deductible if emergency, otherwise 60% after deductible
INPATIENT HOSPITALIZATION				
Facility Services	80% after deductible	60% after deductible	80% after deductible	60% after deductible
Physician & Surgeon's Services	80% after deductible	60% after deductible	80% after deductible	60% after deductible
Penalty for Not Getting Prior Authorization	None	50% penalty applied to hospital inpatient charges; benefits denied for outpatient services	None	50% penalty applied to hospital inpatient charges; benefits denied for outpatient services

CIGNA PPO BENEFITS AT A GLANCE (CONTINUED)

	In-Network Services	Out-of-Network Services	In-Network Services	Out-of-Network Services
STANDARD BENEFIT COVERAGE	**High Option**	**High Option**	**Low Option**	**Low Option**
MATERNITY				
Prenatal & Postnatal Exams	80% Coinsurance, waived after 1st visit	60% after deductible	80% after deductible	60% after deductible
Hospital Delivery	80% after deductible	60% after deductible; Precertification required	80% after deductible	60% after deductible; Precertification required
EQUIPMENT & DEVICES				
Durable Medical Equipment	80% after deductible	60% after deductible	80% after deductible	60% after deductible
External Prosthetics & Orthotics	80% after deductible ($3,000 maximum)	60% after deductible ($3,000 maximum)	80% after deductible	60% after deductible
OUTPATIENT REHABILITATION				
Physical, Speech, & Occupational Therapy	80% after deductible; 60 visits combined maximum/year	60% after deductible; 60 visits combined maximum/year	80% after deductible; 60 visits combined maximum/year	60% after deductible; 60 visits combined maximum/year
Chiropractic Services (chronic conditions not covered; must be medically necessary).	80% after deductible; unlimited	60% after deductible; unlimited	80% after deductible; unlimited	60% after deductible; unlimited
Alternative Medicine; uses designated network	$5 Copay; 10 Self-referral visits/year $60 credit for supplies	Covered in-network only	$5 Copay; 10 Self-referral visits/year $60 credit for supplies	Covered in-network only
OTHER HEALTHCARE FACILITIES				
Skilled Nursing Facilities				
Subscriber Payment	80% after deductible	60% after deductible	80% after deductible	60% after deductible
Limit per Contract Year	90 days/year combined SNF, Rehab Hospital & Sub-acute	90 days/year combined SNF, Rehab Hospital & Sub-acute	90 days/year combined SNF, Rehab Hospital & Sub-acute	90 days/year combined SNF, Rehab Hospital & Sub-acute
Home Health Care	80% after deductible	60% after deductible; 40 days/year	80% after deductible	60% after deductible
FAMILY PLANNING				
Sterilization				
Vasectomy	80% after deductible	60% after deductible	80% after deductible	60% after deductible
Tubal Ligation	80% after deductible	60% after deductible	80% after deductible	60% after deductible
Infertility Services	80% after deductible; Diagnostic Services & Corrective Treatment Only	60% after deductible; Diagnostic Services & Corrective Treatment Only	80% after deductible; Diagnostic Services & Corrective Treatment Only	60% after deductible; Diagnostic Services & Corrective Treatment Only

PHARMACY BENEFIT FOR ALL MEDICAL PLANS

SPONSORED BY MARICOPA COUNTY AND ADMINISTERED BY WALGREENS HEALTH INITIATIVES (WHI)

GROUP NUMBER: 512229

Your pharmacy benefit is selected separately from your medical plan but you may not enroll in the pharmacy benefit unless you have elected a medical plan. There are two pharmacy benefits from which to choose: the Coinsurance Rx benefit and the Consumer Choice Rx benefit.

COINSURANCE RX BENEFIT

The Coinsurance Rx benefit is a multi-tiered plan in which a coinsurance amount (percentage of the cost of the medication) is charged (unless the applicable minimum or maximum threshold is met) based on the drug classification of the medication. This plan covers generic, preferred brand name and non-preferred brand name medications. Some medications require prior authorization or must be used in a certain order (step therapy). Quantity limits apply for certain medications, and some drug classes, such as infertility and cosmetic medications, are excluded.

Tier One covers generic medications. Tier Two covers brand name medications that are on the preferred medication list (PML), which is an approved list of generic and brand name preferred drugs. Tiers three and four cover brand name medications that are not on the PML. Each tier has minimum copayment amounts. Tiers one and two each have maximum copayment amounts. If the minimum or maximum copayments do not apply, then each tier has coinsurance, which is a percentage of the cost of the medication. You will be charged the minimum copayment, the maximum copayment or the coinsurance amount for the medication based on the medication's tier and cost.

The most frequently used generic medications are listed on the PML. Because so many generic medications are available, not all can be listed. However, all generics that meet quality standards are covered. Generic medications are listed in lowercase on the PML.

Preferred brand name medications are also listed on the PML in uppercase.

Non-preferred brand name medications are not listed on the PML. These are brand name medications that are covered at a higher out-of-pocket (OOP) cost.

The coinsurance you pay toward any covered medication will be applied to your maximum OOP limit. The maximum OOP limit is $1,500 for an individual and $3,000 for a family. Once the OOP limit is met, covered medications are paid 100 percent (either for the individual or family) by the plan for the remainder of the year. Any covered member's coinsurance amounts contribute to the family OOP maximum.

As mentioned above, the Coinsurance Rx benefit uses a PML, created and maintained by WHI, the plan administrator. The PML is a tool that guides you and your physician, when selecting medications, toward drugs that maximize your benefit. It is advisable to take a copy of the PML to your doctor's appointment so that the doctor can prescribe medications on the PML, if appropriate.

The brand name of a drug is the product name under which it is advertised and sold. By law, generic drugs must have the same U.S. Food and Drug Administration (FDA) standards for quality, strength and purity as their brand name counterparts. Since the coinsurance for generic drugs is lower, ask your physician about prescribing generic drugs. The pharmacist may also ask your physician whether a generic drug might be appropriate; however, your physician makes the final decision.

The drugs on the PML and drugs newly approved by the FDA are reviewed periodically by WHI's Pharmacy and Therapeutics Committee. The committee is comprised of physicians and pharmacists who are tasked with objectively evaluating drugs for therapeutic treatment, safety and cost-effectiveness in order to determine placement on the PML.

The PML is mailed to newly enrolled participants shortly after enrollment along with an ID card and a registration form for mail order service. The guide is also available via the Internet at WHI's Web site, www.mywhi.com. Please note that the PML is a listing of the drugs that are most commonly prescribed. Other drugs, especially generics, also may be covered. Conversely, since the WHI PML is used for many of WHI's other clients, **not all**

drugs listed on the PML are covered under your pharmacy benefit plan. Your pharmacy benefit plan has certain exclusions and limits that apply. Please refer to the "Exclusions and Limitations" section for more information.

COINSURANCE RX BENEFIT SCHEDULE OF COSTS

RETAIL 30- OR 84-91-DAY SUPPLY

- **Generics (on the PML):** You are responsible for 25 percent of the contracted cost. * The cost of each prescription will be at least $2 but no more than $12 for a 30-day supply or at least $6 but no more than $36 for a three-month (84-91-day) supply.
- **Preferred brand name medications (on the PML):** You are responsible for 30 percent of the contracted cost. * The cost of each prescription will be at least $5 but no more than $30 for a 30-day supply or at least $15 but no more than $90 for an 84-91-day supply.
- **Non-preferred brand name medications (not on the PML) with a generic equivalent:** You are responsible for 50 percent of the contracted cost* plus the difference between the cost of the generic medication and the brand name medication. The cost of each prescription will be at least $20 for a 30-day supply or at least $60 for an 84-91-day supply. There are no maximum amounts for the costs of medications in this category.
- **Non-preferred brand name medications (not on the PML) with no generic equivalent:** You are responsible for 50 percent of the contracted cost. * The cost of each prescription will be at least $20 for a 30-day supply or at least $60 for an 84-91-day supply. There are no maximum amounts for the costs of medications in this category.
- **Specialty pharmacy medications (not on the PML):** You are responsible for a $50 copayment for a 30-day supply of specialty medications for complex health conditions. Specialty medications are received through the specialty pharmacy program, with an emphasis on expensive and difficult-to-find medications, injectables or other medications involving complex administration methods, strict compliance requirements, special storage, handling and delivery, education, monitoring and ongoing patient support. Patient conditions requiring the use of specialty medications include, but are not limited to, acromegaly, chronic granulomatous disease, cystic fibrosis, Gaucher disease, hemophilia, multiple sclerosis, HIV/AIDS, viral hepatitis, some oncology-related conditions, psoriasis, rheumatoid arthritis, growth hormone disorders, respiratory syncytial virus (RSV), solid organ transplant and deep vein thrombosis.

MAIL ORDER 84-91-DAY SUPPLY

- **Generics (on the PML):** You are responsible for 15 percent of the contract cost. * The cost of each 84-91-day prescription will be at least $6 but no more than $28.
- **Preferred brand name medications (on the PML):** You are responsible for 25 percent of the contract cost. * The cost of each 84-91-day prescription will be at least $15 but no more than $70.
- **Non-preferred brand name medications (not on the PML) with generic equivalent:** You are responsible for 50 percent of the contract cost* plus the difference between the cost of the generic and brand name medications. The cost of each 84-91-day prescription will be at least $60. There are no maximum amounts for the costs of medications in this category.
- **Non-preferred brand name medications (not on the PML) without a generic equivalent:** You are responsible for 50 percent of the contract cost. * The cost of each 84-91-day prescription will be at least $60. There are no maximum amounts for the cost of medications in this category.
- **Specialty pharmacy medications (not on the PML) received through home delivery**: You are responsible for $50 for a 30-day supply.

**Contracted cost is the discounted average wholesale price of the prescription plus the dispensing fee.*

NOTE: If you have CIGNA as your medical insurance, then diabetic supplies and medications may be obtained at a CIGNA Medical Group facility for $10 per item. If you have HealthSelect as your medical insurance, then diabetic supplies may be obtained through Walgreens Home Care for a $0 copayment.

CONSUMER CHOICE RX BENEFIT

The Consumer Choice Rx benefit is a multi-level plan in which Maricopa County fully funds the first level (pharmacy account), you fund the second level (deductible), and you and Maricopa County share the cost of the third level (insurance) through coinsurance. Any unused portion of the pharmacy account is rolled over to the next benefit year, creating a credit balance that you can use to pay for future prescriptions.

The benefit is geared towards smart spending at all levels with the most cost-effective medication. No PML is used to manage this benefit because much of the management of this benefit is up to you. Some medications require prior authorization. Certain medications that could be used in a cost-effective order (step therapy) have messages advising the pharmacist to alert you if you have chosen a more expensive medication when a more cost-effective medication is available. You may also receive a letter in the mail advising you of a less expensive alternative to your current medication. Quantity limits apply to certain medications, and some drug classes, such as infertility and cosmetic medications, are excluded.

The amounts you pay toward any covered medication will be applied to your maximum out-of-pocket limit. The maximum out-of-pocket limit is $1,500 for an individual and $3,000 for a family. Once the out-of-pocket maximum is met, covered prescriptions are paid 100 percent (either for the individual or family) by the plan for the remainder of the year. Any covered member's coinsurance amounts contribute to the family out-of-pocket maximum.

- **Pharmacy Account:** The account is funded 100 percent by Maricopa County as a credit balance at the rate of $200 per individual or $400 per family. You use the credit to pay for prescription medications at the contracted cost. * Any unused credit rolls over to the next benefit year.
- **Deductible (Employee Responsibility):** The deductible is funded 100 percent by you at the rate of $200 per individual or $400 per family. You spend your deductible amount toward your prescription medications at the contracted costs. * If you have enrolled in the Mariflex FSA, you can use your pre-taxed funds to be reimbursed for medication costs at this level.
- **Insurance:** The insurance level covers the cost of the medication at 80 percent of the contracted cost * of the medication. You pay 20 percent of the contracted cost. * If you have enrolled in the Mariflex FSA, you can use your pre-taxed funds to be reimbursed for medication costs at this level.
- **Specialty pharmacy medications:** These medications will not be charged against your pharmacy account or deductible. Instead, a $50 copayment will be charged for each prescription. The copayment amounts will be applied toward the out-of-pocket maximums. Specialty medications are received through the specialty pharmacy program for complex health conditions, with an emphasis on expensive and difficult-to-find medications, injectables or other medications involving complex administration methods, strict compliance requirements, special storage, handling and delivery, education, monitoring and ongoing patient support. Patient conditions requiring the use of specialty medications include, but are not limited to, acromegaly, chronic granulomatous disease, cystic fibrosis, Gaucher disease, hemophilia, multiple sclerosis, HIV/AIDS, viral hepatitis, some oncology-related conditions, psoriasis, rheumatoid arthritis, growth hormone disorders, respiratory syncytial virus (RSV), solid organ transplant and deep vein thrombosis.

**Contracted cost is the discounted average wholesale price of the prescription plus the dispensing fee.*

OBTAINING COVERED PRESCRIPTIONS

With either the Coinsurance Rx or the Consumer Choice Rx benefit plan, you can obtain your prescriptions from three different sources, depending on your needs.

Short-Term Needs: Up To a 30-Day Supply at WHI Network Retail Pharmacies

The retail network of pharmacies is available for prescriptions you need right away, for a short time only (such as antibiotics) or on a monthly basis. You can choose from more than 54,000 participating network pharmacies nationwide, and you can obtain, at one time, up to a 30-day supply. You can find the nearest participating network pharmacy by calling WHI Member Services at 1-800-207-2568 or by going online to www.mywhi.com. A small number of medications, such as, but not limited to, Accutane or Peg-Intron, are limited to a 30-day-or-less supply. These specialty medications may only be purchased at a participating Walgreens retail pharmacy.

Long-Term Needs: Three Month Supply at Certain Retail Pharmacies

When you need prescriptions for chronic or long-term health conditions (such as, but not limited to, high blood pressure, diabetes or asthma) you can purchase a three-month supply at any pharmacy located in a **Walgreens, Osco, Albertsons or CVS.** If you are a HealthSelect member and your prescription is written by a Comprehensive Health Center (CHC) or FHC physician, you can receive a three-month supply at any one of the MIHS pharmacies located in the CHCs and FHCs. The physician must write the prescription for an 84–91-day supply or the medication will be filled based on a 30-day retail supply.

Note: Any prescription written for a 31–83-day supply will not be filled under your pharmacy benefit. If you choose to fill the prescription anyway, the full cost of the medication will be your responsibility.

Long-Term Needs: Three Month Supply through the Mail Service Pharmacy: Walgreens Mail Service

Prescriptions for maintenance medications or long-term health conditions can also be ordered through the Walgreens Mail Service pharmacy. Ordering through the mail is both a safe and convenient way to receive prescriptions and may save you money.

You must use a specific order form when placing your first order. This form provides Walgreens Mail Service with important health, allergy and plan identification information. This form is called the **Tempe Registration and Order Form** and is available online at the Benefits Home Page or at WHI's Web site at www.mywhi.com. You can even register online at the WHI Web site instead of completing a hard copy of the form. **Forms are not available through Walgreens Customer Service.**

Send the completed form along with your original written prescription to **Walgreens Mail Service, PO Box 29061, Phoenix, AZ 85038-9061**. Be sure to include your group number, **512229**, on the form. You may pay by check, money order, Visa, MasterCard, Discover or American Express. Please do not send your debit card number or cash.

Your doctor may not phone in new prescriptions. However, your doctor may send a new prescription via facsimile (fax). The required form is called the **Tempe Physician Fax Order Form** and is available by going to www.mywhi.com and selecting the Mail Service Pharmacy tab.

Drug Utilization Alerts at Time of Purchase

Drug Utilization Review (DUR) is an effective tool in monitoring drug use to assure that it is appropriate, safe and effective. WHI's point-of-service DUR program monitors claim submissions across all pharmacies and physicians, compares each claim with the active prescriptions of individual members and sends "flags" back to the pharmacist should any drug interaction occur. The DUR system adheres to the National Council for Prescription Drug Products (NCPDP) DUR guidelines and monitors every prescription for numerous conditions such as drug interactions, over-utilization and therapeutic duplication. The pharmacist may decide not to dispense medication based on the DUR alert received at the point of service.

Prior Authorization

Certain medications for which appropriate utilization must be determined require prior authorization, or approval, before they will be covered. Additionally, some medications with specific quantity limits within a set timeframe or which must be taken in a special order (step therapy), or when an age limitation has been reached and/or exceeded require prior authorization. WHI administers the clinical prior authorization (CPA) process.

Your pharmacist, physician or you and/or your dependents may initiate the CPA process by calling 1-877-665-6609 8 a.m.- 8 p.m. CST Monday through Friday. You will need the following information when you request CPA or want to know if a particular medication requires CPA:

- Name of the medication,
- The prescribing physician's name, phone number (and fax number, if available),
- Your WHI identification number, and
- Your group number: 512229.

If your request for CPA results in a denial, you may file an appeal by completing an appeal form and submitting medical documentation of the medical necessity for the medication. The appeal form is available on the Benefits Home Page.

Categories/medications that require CPA include, but are not limited to:

- Anabolic steroids (all forms)
- Insomnia
- Anti-obesity
- Anti-Fungals (e.g., Lamisil, Sporanox)
- Migraine Medications (all forms of treatment)
- Leukotrienes (e.g., Singulair)
- Botulinum Toxins (e.g., Botox)
- Growth Hormone

Age Limitations

Certain medications have an age limitation and include, but are not limited to, the following health conditions:

- Topical Acne
- Attention Deficit Hyperactivity Disorder (ADHD)
- Narcolepsy

Your claim will be denied at the time of purchase if it exceeds the limitations for medications for these conditions. A CPA, as described above, may be requested upon such denial.

QUANTITY LIMITATIONS

Certain medications have quantity limitations and include, but are not limited to, the following health conditions and medications:

- Impotency*
- Insomnia
- Migraine Medication
- Stadol
- Diflucan

Once the limitation has been reached, if an additional supply is required, a CPA, as described above, may be requested. *Impotency medication has a set monthly limitation that is not subject to CPA or the appeals process.

STEP THERAPY

In some instances, the Coinsurance Rx benefit may require that a therapeutically equivalent prerequisite medication be tried before other medication is approved. This is called step therapy.

Drug categories or medications that require step therapy include, but are not limited to:

- Proton Pump Inhibitors (PPIs such as Prilosec, Prevacid, Nexium, Protonix and Aciphex)
- Cox II inhibitors (e.g., Celebrex and Bextra)

DIRECT MEMBER REIMBURSEMENT

Your pharmacy benefit is valid only through the WHI network of pharmacies. Should the situation arise where you require medication and must pay for it yourself, keep your receipt(s). You may request a direct member reimbursement (DMR) by completing the DMR form and submitting it to the Benefits Office. The DMR form is available at the Benefits Office or via the Benefits Home Page.

The Benefits Office will make a determination, and, if approved, forward your claim to WHI to process your request for reimbursement according to the plan's guidelines, coverage and limitations. If the request is approved, you should receive your reimbursement within approximately four weeks.

Please note that WHI will reimburse you according to the plan's guidelines. You will receive the contracted amount of the medication, less your coinsurance, rather than the full retail price of the medication less your coinsurance. For this reason it is important for you to use a participating WHI pharmacy and to have your ID card readily available to show the pharmacist. Your ID card contains important information to assist with the processing of your claim.

MAXIMUM OUT-OF-POCKET BENEFIT

The coinsurance you pay toward any covered drug will be applied to your maximum out-of-pocket (OOP) limit. The maximum OOP limit is the most you or your family will pay for covered prescription medications during a calendar year.

- The maximum OOP for individual coverage is $1,500.
- The maximum OOP for family coverage is $3,000.

Once you and/or your eligible dependents meet your OOP maximum, covered prescriptions are paid at 100 percent (either for the individual or family) by the plan for the remainder of the calendar year. Any covered member's coinsurance amounts contribute to the family OOP maximum.

The amount you pay for any *non-covered drug,* the excess amount you pay when using a non-participating pharmacy or the amount you pay for a prescription that did not process through the WHI pharmacy system will not be included in calculating the annual OOP maximum. You are responsible for paying 100 percent of the cost for any non-covered drug. However, the contracted rates will be available to you.

COVERED ITEMS

The following items are covered under the prescription program (unless specifically listed in the "Exclusions and Limitations" section below).

- Federal legend drugs (drugs that federal law prohibits dispensing without a prescription)
- Compound prescriptions containing at least one legend ingredient
- Insulin and diabetic medications such as blood glucose monitors, test strips, glucagon, lancets (including automatic lancing devices), prescribed oral agents for controlling blood sugar, disposable insulin syringes and

any of the devices listed above that are needed due to being visually impaired or legally blind.

Note: Insulin cartridges are available through your medical insurance carrier's durable medical equipment (DME) provider. Restrictions apply.

EXCLUSIONS AND LIMITATIONS

- Drugs used for cosmetic purposes, including, but not limited to, anti-fungals, hair loss treatments and those used for pigmenting/depigmenting and reducing wrinkles.
- Fertility drugs (oral and injectable).
- Diabetic urine tests and alcohol swabs.
- Nutritional/dietary supplements. **Note**: Medical food products (low protein foods and metabolic formula) to treat inherited metabolic disorders (a disease caused by an inherited abnormality of body chemistry) are covered under your medical plan according to Arizona state statute.
- Over-the-counter medications and other over-the-counter items.
- Injectables obtainable through and administered by a physician in an office setting. If the medication is available and administered through your physician's office, then it may be covered through your medical plan.
- Miscellaneous medical supplies.
- Prescription drug products for an amount dispensed which exceeds the supply limit (days supply or quantity limit).
- Prescription drug products for any condition, injury, sickness or mental illness arising out of, or in the course of, employment, for which benefits are available under any workers' compensation law or other similar laws, whether or not a claim for such benefits is made or payment or benefits are received.
- Charges to administer or inject any drug.
- Prescription drugs that are not medically necessary.
- Charges for delivering any drugs, except through the mail service benefit. Express or overnight delivery costs are not covered.
- Experimental or investigational medications.
- Prescription drugs purchased from an institutional pharmacy for use while you are an inpatient in that institution regardless of the level of care.
- Reimbursement for prescription drugs purchased from a non-participating pharmacy is limited to the contract rate less coinsurance.

This is a brief summary of your pharmacy benefit. For more information regarding your pharmacy benefit, contact the WHI Member Services Department at 1-800-207-2568 Monday through Friday, 24 hours a day. Identify yourself as a Maricopa County employee and specify the pharmacy benefit plan — Coinsurance Rx or Consumer Choice Rx — about which you are inquiring. A Member Services Representative can assist you in locating participating pharmacies, answering plan design questions, providing information on PML medications, determining a medication's coinsurance or copayment purchase amount and informing you of alternative medications you and your physician may consider to minimize your out-of-pocket expense.

Walgreens Mail Service Member Service is available by calling 1-888-265-1953 Monday through Friday from 7 a.m. to 7 p.m. MST and Saturday from 7 a.m. to noon MST. For mail order refills, call 1-800-797-3345 Monday through Friday from 7 a.m. to 7 p.m. MST and Saturday from 7 a.m. to noon MST.

You may visit the WHI Web site at www.mywhi.com for many resources and services, including online mail order registration and refill orders; locating a pharmacy and viewing a PML; information on specific medications, coinsurance amounts for medications, a history of medications filled through your pharmacy benefit including your cost of medication and the plan's cost of the medication, and alternative medications that may save you money. At the site, you can also find product news, specialty pharmacy information for complex health conditions and the Walgreens.com Health Library featuring Mayo Clinic Health Information. Services you can access through the link to the Walgreens.com Health Library featuring Mayo Clinic Health Information or by visiting www.walgreens.com include Ask a Pharmacist, where a Walgreens pharmacist offers expert confidential answers to any questions you may have; a drug interaction checker, immunization recommendations and much more. You may also refer to the Maricopa County Pharmacy Benefit Summary Plan Document through the Benefits Home Page.

VISION BENEFIT PLAN

PROVIDED BY AVESIS

GROUP NUMBER: 10790-95

PLAN NUMBER: 943

The Avesis vision benefit is provided to you and your eligible dependents enrolled in HealthSelect or CIGNA medical plans. If you waive your medical coverage, you may enroll in a separate stand-alone vision plan with the entire premium costs paid by you.

Avesis offers a vision benefit where you may choose services from a participating network provider (in-network) or a non-participating provider (out-of-network). However, when you select a participating network provider, you are assured quality care and maximum savings. If you purchase non-covered options (specialty lenses, additional eyewear, tints, coatings, etc.) from a participating network provider, you receive significant savings.

You may choose from one of three in-network options or you may choose to receive your vision benefit from an out-of-network provider. If you choose to receive your vision benefit through a non-participating provider, you must pay the provider and submit an itemized statement for reimbursement of your vision care expenses within three months from the date of service. When filing an out-of-network claim, you must provide the following information: employee name and identification number, mailing address, patient name and date of birth, and group number.

VISION BENEFITS AT A GLANCE

Benefits	In-Network Options Charges/Costs		Out-of-Network Charges/Costs
	Option One (Glasses)	Option Two (Contact Lenses)	
Routine Vision Exam	$10 copayment	$10 copayment	Maximum Benefit $35
Single Spectacle Lenses (pair) Includes Polycarbonate, clear glass or CR39 basic plastic	$10 combined copayment Standard lenses/frames copayment		
Single Vision Lenses			Maximum Benefit $25
Bifocal Lenses			Maximum Benefit $40
Trifocal Lenses			Maximum Benefit $50
Lenticular			Maximum Benefit $80
Frame (within plan allowance)			Maximum Benefit $45
Tints and Coatings	20% of UCR	N/A	Not Covered
Contact Lenses-Elective as determined by Avesis	N/A	$130 allowance applied toward contact lenses and/or professional fitting fees. $10 copayment for exam.	Maximum Benefit: $130 applied toward contact lenses and/or professional fitting fees.
Contact Lenses-Medically Necessary as determined by Avesis		$10 copayment for exam.	Maximum Benefit $250 applied toward exam, contact lenses and related professional fitting fees.
Option Three (LASIK Surgery Benefit)			
LASIK Surgery	One-time (lifetime) benefit. Takes the place of all other benefits for the benefit year. Through an Avesis contracted provider only. $150 allowance applies toward the cost of the LASIK surgery for one or both eyes.		Not Covered

This is a brief summary of your benefits. For more information regarding your vision benefit, contact the Avesis Customer Service Department at 1-800-828-9341 from 7 a.m. to 5 p.m. MST Monday through Friday. When calling the Avesis Customer Service Department, please identify yourself as a Maricopa County employee. In addition, for assistance in selecting a provider, you may visit the Avesis Web site at www.avesis.com.

You may also refer to the Avesis brochure and provider directory on the Benefits Home Page.

BEHAVIORAL HEALTH AND SUBSTANCE ABUSE SERVICES

GROUP NUMBER: 12488

PROVIDED BY UNITED BEHAVIORAL HEALTH (UBH)

The behavioral health benefit, which is provided to you and your covered dependents enrolled in the HealthSelect or CIGNA medical plans (except for CIGNA PPO Low Option), provides services that support your well being.

These services help you deal with a wide range of issues, including:

- Depression
- Severe stress and anxiety
- Alcohol or drug dependency
- Legal concerns
- Eating disorders
- Grief and loss
- Anger management
- Financial worries
- Compulsive gambling
- And more

Through these services you can receive confidential counseling whenever you and/or your eligible dependents are faced with a personal challenge. Protecting your confidentiality is UBH's top priority. All records, including personal information, referrals and evaluations, are kept confidential in accordance with federal and state laws.

Provided below is a summary of your benefits. It is important for you to understand that in-network benefits received through a participating provider are payable only if each service is determined to be medically necessary and is approved by UBH before you start treatment. Contact UBH at 1-866-312-3078 for prior approval. Out-of-network services received through a non-participating provider do not require prior approval; however, out-of-network services are limited to outpatient therapy and the benefit is limited to $25 of the provider's billed charges. You are responsible for the remaining amount of billed charges when you receive services through a non-participating provider.

UNITED BEHAVIORAL HEALTH BENEFITS AT A GLANCE

	In-Network	Out-of-Network
Deductible	None	None
Inpatient Hospital Care, 30 days per year	$25/day copayment	Not Covered
Intensive Outpatient Program	$100 copayment per program	Not Covered
Outpatient Individual Therapy Visits (in-network and out-of-network visit limit is combined; 30 visits per year)	$10/visit copayment	Benefit pays $25 per visit; you pay the balance of the charges
Outpatient Group therapy Visits (in-network and out-of-network visit limit is combined; 60 visits per year)	$5/visit copayment	Benefit pays $25 per visit; you pay the balance of the charges
Residential Treatment, 60 days per year	$12.50/day copayment	Not covered
Behavioral Health/Substance Abuse Lifetime Maximum	Unlimited	$5 million

For more information regarding your behavioral health benefit, to obtain prior approval or to find participating providers, contact the UBH Member Services department at 1-866-312-3078 24 hours a day, seven days a week. In addition, Member Services can assist you with the many features you will find when visiting the UBH Web site at www.liveandworkwell.com. This Web site contains information and resources to maximize your well being, including interactive self-improvement programs, health and wellness articles, community resources, and information on free legal services and discounts and free financial consultations with certified financial planners. ***The access code to this Web site is 12488.***

Note: If you waive your medical coverage, you are not covered for behavioral health and substance abuse services.

In addition to behavioral health and substance abuse services administered by UBH, Sheriff's Office employees and their dependents may access the Sheriff's Office Behavioral Health Services Unit (BHSU).

EMPLOYEE ASSISTANCE PLAN

PROVIDED BY COMPSYCH GUIDANCE RESOURCES

The Employee Assistance Plan (EAP) is an employer-paid benefit that provides short-term counseling for both personal and work-related issues for you and your dependents regardless of whether you and/or your dependents are benefit eligible or waive your medical coverage. There is no premium or copayment to you for this service. The behavioral health benefit offered through UBH is similar to your EAP benefit. In fact, UBH and ComPsych Guidance Resources work together to ensure that you receive the most appropriate care. Since the EAP is offered to you with no copayment, you may want to consider contacting ComPsych first for your short-term needs to minimize your out-of-pocket (OOP) costs. ComPsych will refer you to your behavioral health provider, UBH, if appropriate.

Why is an EAP needed?

Sometimes employees face problems that they cannot solve. Concerns can become overwhelming and affect work performance, personal happiness, family relations and health. When this occurs, professional help may be needed to resolve the problem before it becomes a larger issue.

What services does ComPsych Guidance Resources provide?

Your EAP provides a full range of counseling and referral services for individual, family and marital concerns; stress- and job-related matters; child and domestic abuse; and chemical and alcohol dependency assessment. Counseling is available by phone or in person, depending on your preference.

Other services provided are:

- 24-hour crisis intervention;
- Assessment and short-term counseling for personal and work-related problems;
- Referral to professionals and treatment resources throughout Maricopa County for ongoing specialized counseling;
- Information and referral to community resources for social service issues (legal concerns, child and elder care, budgeting, self-help groups, etc.).

How many visits are allowed?

Your EAP benefit provides up to eight individual counseling sessions for you and your dependents per person, per problem, per year. There are no copayments for these sessions. You may use six sessions per year during work hours (with the prior approval of and coordination with your supervisor) without using family medical leave (FML) or paid time off (PTO).

Who pays for EAP services?

Maricopa County pays for EAP services. There is no charge to you or your dependents for this service.

How is confidentiality protected?

ComPsych Guidance Resources provides the strictest confidentiality possible, as set forth in state and federal statutes. If sufficient need is shown, upon your approval, your counselor may encourage other members of your family to participate. Release of information by the EAP concerning an individual can be given only with your written consent, except where required by law (e.g., suspected of child abuse or posing a danger to self or others).

To make an appointment, call ComPsych Guidance Resources at 1-888-355-5385 24 hours a day, seven days a week. You can expect to obtain an appointment within five to seven business days. You can also access legal and financial advisement as well as information on mental health topics by going to the ComPsych Web site at www.guidanceresources.com. The Maricopa County identification code is **MC2003**.

In addition to EAP services administered by ComPsych Guidance Resources, Sheriff's Office employees and their dependents may access the Sheriff's Office BHSU.

DENTAL PLANS

Maricopa County employees may purchase dental insurance from one of two dental vendors, United Concordia or Employers Dental Services (EDS). Dental coverage may be purchased if you waive medical insurance coverage.

SPONSORED BY MARICOPA COUNTY AND ADMINISTERED BY UNITED CONCORDIA

GROUP NUMBER: 815151

United Concordia's dental plan gives you freedom of choice in selecting your dental provider by offering a product with in-network and out-of-network benefits.

A dentist participating in United Concordia's network will submit your claim, receive direct payment from United Concordia and accept the fee paid as payment in full (after your deductible and/or coinsurance).

Using a participating dentist costs you less because services are covered at a higher percentage. Class I (Diagnostic & Preventive Services) is covered 100 percent and Class II (Basic Restoration Services) is covered at 80 percent. Class III (Major Services) is covered at 50 percent.

When using a non-participating dentist, you can assign payments to that dentist by signing the claim form appropriately. If you do this, your dentist will likely submit the claim for you since this means United Concordia will pay the dentist directly. If the dentist will not bill United Concordia, you are responsible for submitting the claim. Additionally, use of a non-participating dentist will cost more because services are covered at a lower percentage than when services are provided by a participating dentist. Class I (Diagnostic & Preventive services) is covered at 80 percent and Class II (Basic Restoration) is covered at 60 percent. Class III (Major Services) is covered at 50 percent.

United Concordia compensates all dentists according to its maximum allowable charge (MAC) schedules. Participating dentists agree to accept these allowances as payment in full for covered services less applicable coinsurance and deductibles. Non-participating dentists are under no obligation to accept the payment as full payment, and will bill you for the difference between the billed charges and United Concordia's MAC schedule.

A pre-determination of benefits is not required to access services, but is recommended before you begin treatment for complex procedures such as crowns, bridges, dentures or non-acute periodontal surgery. If you use non-participating dentists, consider having a pre-determination of benefits completed before beginning any treatment so you will know whether the service is covered and exactly what your financial responsibility will be before incurring the charges.

Claim forms, the summary of benefits, the plan document and provider directory are available through the Benefits Home Page by clicking on the link for United Concordia Dental. Assistance is also available by calling United Concordia's customer service department at 1-800-332-0366 from 8 a.m.-5 p.m. PST Monday through Friday or by accessing the Web site at www.ucci.com. A chart comparing the benefits of both dental plans follows the description of the Employers Dental Services (EDS) dental plan. Before using services, please refer to the full summary of benefits and plan document, available through the Benefits Home Page, for more specific information regarding plan limitations and exclusions.

PROVIDED BY EMPLOYERS DENTAL SERVICES (EDS)

GROUP NUMBER: 11931

Employers Dental Services (EDS) is a managed care dental organization that provides a dental plan option for Maricopa County employees. The advantages of selecting a managed care dental organization dental plan include no deductible, no claim forms, no yearly maximums, orthodontic services for children and adults, a prescription discount program, a large network of participating dentists, 24-hour-a-day emergency care and affordability with a focus on preventive procedures.

Specialty dental care is not a covered benefit under this plan, but such care is available at a discount when provided by an EDS specialist. A discount for the treatment of temporomandibular joint (TMJ) pain is also available. A referral is not required to see an EDS specialist.

Immediate coverage is available for basic, preventive and major services. EDS covers pre-existing conditions, except for procedures in progress at the time of enrollment. As an EDS member, you choose a general dentist from the network of participating dentists. All members of your family choose the same dentist. You have the

freedom to change dentists, with all changes received by the 20th of the month becoming effective the first of the following month.

A brief summary of benefits is shown below. The coverage booklet and links to the EDS Web site are available through the Benefits Home Page by clicking on the link for EDS Dental. The Dentist Search database on the EDS Web site at www.mydentalplan.net is updated every two weeks. The most recent provider directory is located under the Member Tools menu.

EDS Customer Service is also available to answer your questions by calling 602-248-8912 Monday through Friday from 8 a.m. to 5 p.m. MST. Customer Service can help you select a dentist, change your current dentist, explain your benefits and costs, process your request for a new ID card, resolve a concern, explain the grievance process and facilitate care for a dental emergency.

Please refer to the full coverage booklet for more specific information regarding plan limitations and exclusions before using services.

DENTAL PLANS COMPARED

Features	United Concordia	Employers Dental Services
Annual Calendar Year Maximum per person	$2,000	None
Orthodontic Service	Diagnostic, active and retention treatment 50% coinsurance Adults and Child $3,000 Lifetime Orthodontic Maximum effective for treatment plans beginning on or after Jan. 1, 2005; lifetime maximum will be coordinated with prior group insurance carrier; continuing services previously covered under a pre-paid dental plan will not be covered.	25% discount on all orthodontic services Metal banding, invisible braces, and Invisalign braces are covered Appliances such as expanders, reverse headgear, Herbst, Pendulum, Nance, Tongue Crib, Jaspers, Sagittal, and Schwartz Prices on which the discount is calculated may vary by orthodontist
Provider Network Access	In-Network (participating) and Out-of-Network, (non-participating) providers both available	Must use EDS contracted dentists
Deductible	$50 per person/$100 per family (waived for diagnostic, preventive and orthodontic services) combined for in- and out-of-network services	None
Class I (Diagnostic and Preventive Services)	100% coverage for Diagnostic, Preventive, and Palliative Services Routine Oral Exams/ cleanings (twice/year) X-rays (limits apply) Sealants of permanent molars (through age 15) Fluoride (twice per year through age 18) In-network 100% of maximum allowable charge Out-of-network 80% of maximum allowable charge*	Diagnostic and Preventive Services (at general dentist): Office visit/$3 Routine Oral Exam - $0 Cleaning - $0 Oral exam - $0 X-rays - $0 Sealants -$12 per tooth Fluoride - $0 Emergency Services - up to $200 reimbursement less applicable copayment(s)
Class II (Basic Restoration Services)	Basic Services 80% coverage Amalgam fillings on posterior teeth Resin/Composite fillings on anterior teeth Oral Surgery Endodontics Periodontics Repair of denture and bridgework Simple extractions Complex Oral Surgery General Anesthesia In-network 80% of maximum allowable charge Out-of-network 60% of maximum allowable charge*	Basic Services (at general dentist): Fillings (amalgam) $8 - $21 copayment Fillings (resin) $22 - $40 copayment Oral Surgery: from $35 copayment Endodontics: root canal $170 - $265 copayment Periodontics: debridement $80 copayment; Scaling and root planing/quadrant $90 copayment
Class III (Major Services)	Major Restorative 50% coverage Resin/Composite fillings on posterior teeth Inlays, Onlays, Crowns Partial or complete dentures Fixed bridges In-Network 50% of maximum allowable charge Out-of-network 50% of maximum allowable charge*	Major Restorative (at general dentist): Crown porcelain w/metal $250 copayment + lab fee Complete dentures upper or lower $325 copayment for each + lab fee Partial dentures upper or lower (resin base) $375 copayment for each + lab fee Bridge per pontic $250 copayment + lab fee

*If the non-participating out-of-network dentist charges more than the maximum allowable charge, you are liable for the difference between the MAC and the billed amount, in addition to your deductible and coinsurance.

LIFE INSURANCE PLAN

PROVIDED BY UNUMPROVIDENT CORPORATION

POLICY NUMBER: 584741

Your basic life, accidental death and dismemberment, supplemental life and dependent life insurance are provided through UNUMProvident. Medical underwriting may be required when you make your election. Rates for supplemental and dependent life insurance are found in the "2005 Premium Rates" section.

BASIC TERM LIFE WITH ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D) INSURANCE

The County provides you with, and pays 100 percent for, a basic term life insurance benefit equal to your base salary, up to $500,000 per year, (excluding overtime, bonus or commissions) rounded to the next highest $1,000. Coverage begins the first day of the month following your date of hire. Life benefits are paid for any cause of death. In addition to the death benefit, AD&D benefits are paid if an accident is the cause of death.

SUPPLEMENTAL TERM LIFE WITH ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D) INSURANCE

If you want to increase your protection in addition to the basic life and AD&D coverage provided by the County, you can purchase supplemental term life and AD&D insurance. In all cases, evidence of insurability is required when the coverage is greater than $500,000 (basic and supplemental combined). The Evidence of Insurability form is available at the Benefits Office or on the Benefits Home Page. The maximum insurance coverage you can purchase is $1 million (basic and supplemental combined). All life insurance amounts are rounded to the next highest $1,000 of your annual salary. You may reduce or cancel your coverage for supplemental life coverage at any time.

If purchased as a new hire, you can elect supplemental coverage in amounts of one to five times your annual salary without evidence of insurability unless the sum total of your basic and supplemental insurance is greater than $500,000. If you have elected a level of supplemental insurance that, when combined with basic insurance, is greater than $500,000, you will be enrolled for coverage up to $500,000 until your evidence of insurability application for additional insurance has been approved.

If you didn't enroll in supplemental insurance when first eligible, you may enroll in the first level (one times your annual salary) at any time without evidence of insurability unless basic and supplemental coverage combined is greater than $500,000. At any time, you may apply for any other option (two to five times your annual salary), at which time evidence of insurability will be required.

If you experience a qualified status change, you can, within 30 calendar days of that change, increase your coverage (one to five times your annual salary) without completing an evidence of insurability form, unless the requested amount (basic and supplemental combined) is greater than $500,000. If you are applying for any amount of life insurance over $500,000 (basic and supplemental combined) and you complete an evidence of insurability form, if you are not approved for the increase in your coverage, you will remain at the same level you had prior to applying for the increase. However, if your current level is below the evidence of insurability requirements, your coverage will be increased to the next level as long as that level does not exceed the evidence of insurability requirements. To learn what constitutes a qualified status change, refer to "What is a Qualified Status Change?" section.

During an annual open enrollment period, you can increase your supplemental coverage by one level without completing an evidence of insurability form. If you increase your coverage greater than one level or if your combined basic and supplemental insurance is over $500,000, you must complete an evidence of insurability form. If you are not approved for the increase in your coverage, you will remain at the same level you had prior to applying for the increase. However, if your current level is below the evidence of insurability requirements, your coverage will be increased to the next level as long as that level does not exceed the evidence of insurability requirements.

For all employees who are required to complete an evidence of insurability form, UNUMProvident will review the information and make a determination whether to approve or deny your request for additional coverage. UNUMProvident may request additional information, including, but not limited to, medical records, when making a determination. Coverage and the associated premium do not become effective until UNUMProvident approves your request. The effective date of coverage is the date of approval and is <u>not</u> retroactive to the date of completion of the form.

TERMINAL ILLNESS BENEFIT

If you or your covered dependent(s) are diagnosed with a terminal illness and life expectancy is less than 12 months, you may apply for the accelerated death benefit or 50 percent of your supplemental life insurance benefit up to $500,000, whichever is less.

SPECIAL RATES FOR NON-SMOKERS

As part of the County's commitment to good health, a reward is offered for leading a healthier lifestyle. If you are a non-smoker, your supplemental life insurance premiums are lower than those of an employee who smokes.

Note: The life insurance contract has an incontestability clause, which states that any statements made by an employee and found to be untrue or incomplete at the time they are made can result in a reduction or denial of any claim made during the first two years of coverage.

DEPENDENT LIFE COVERAGE

In addition to basic and supplemental life insurance for yourself, you can choose one of two levels of life insurance for your eligible dependents.

Note: You may not cover your spouse as a dependent if he or she is enrolled for basic life coverage as an employee.

BASIC AND SUPPLEMENTAL LIFE INSURANCE PORTABILITY

If your employment ends, you retire from Maricopa County, you are on active duty military leave or personal leave for more than 90 days or you become ineligible for benefits, you may elect portable coverage for yourself and your dependents. The portable insurance will be for your current coverage amount and any amounts for which your dependents are insured, up to $750,000. The cost of the coverage will differ from the current amount you are paying. You and the Benefits Office must complete portions of the Life Insurance Election of Portability Coverage form. The form and rates to determine the monthly premium are available on the Benefits Home Page under the Forms link. Once the form is completed, you must send it to UNUMProvident with the first month's premium, within 45 days of the time you lose your eligibility.

BENEFICIARY

You should name a beneficiary for your basic and/or supplemental death benefits when you become insured. You may name primary and secondary beneficiaries, and you may name more than one beneficiary as primary and more than one beneficiary as secondary.

If you are not married, you may allocate benefits by percent or amount. If you are married, you may allocate the benefit only as a percentage. This is because if you are married, you must designate at least 50 percent of your death benefits to your spouse unless your spouse signs the Spousal Waiver section on the Beneficiary Designation form, and has it notarized and delivered to the Benefits Office. The Beneficiary Designation form is located on the Benefits Home Page under the Forms link.

If you allocate your benefit as a percentage, ***you must use a whole percentage***. Primary beneficiary designations must equal 100 percent. Secondary beneficiary designations also must equal 100 percent.

If you allocate your benefits as an amount, you also must use whole numbers and you must designate a beneficiary to receive any remaining amount.

You may change your beneficiary at any time. The new beneficiary designation will be effective as of the date you complete a Beneficiary Designation form, submit an electronic designation during open enrollment or make a beneficiary change online through Employee Self Service.

SHORT-TERM DISABILITY BENEFITS

SPONSORED BY MARICOPA COUNTY AND ADMINISTERED BY VPA, INC.

GROUP NUMBER: 435000

VPA, Inc. administers your short-term disability (STD) benefit. The STD plan pays benefits if you are unable to work and lose income because of a covered illness or injury for which you are being treated.

The Short-Term Disability Summary Plan Document is available on the Benefits Home Page by clicking on the Disability Management link. Information is also available by calling VPA at 800-599-7797 Monday through Friday, 5 a.m.-5 p.m. PST or by contacting Disability Management at 602-506-1010, Monday through Friday, 8 a.m.–5 p.m. MST. Before enrolling or using services, please refer to the full STD Plan Document for specifics on plan coverage, limitations and exclusions. There is a pre-existing condition that applies to the receipt of STD benefits. If you have a condition related to your disability for which you received treatment (including diagnostic services and/or prescription drugs), or for which a prudent person would have received treatment, 90 days before your coverage became effective, no benefits will be payable for that condition until you have been treatment-free for three months or covered by the plan for 12 months. The pre-existing condition will also be applied to the difference between the current and increased benefit level change made during open enrollment. Additionally, participation in various case management programs is mandatory, and, if you have a disability that appears to be long-term, you are required to apply for long-term disability through the Arizona State Retirement System (ASRS), if eligible.

You can choose one of the following benefit levels, subject to a $1,000 maximum weekly benefit.

- 40 percent of base weekly salary
- 50 percent of base weekly salary
- 60 percent of base weekly salary
- 70 percent of base weekly salary

Once you make an election, you may increase or decrease your coverage only during a regularly scheduled open enrollment period. Coverage cannot be cancelled until the next open enrollment period, even if you have a qualified status change. **Note:** If your weekly disability payment is at the $1,000 per week maximum (depending on your salary), you may be enrolling in and paying for a percentage level that you cannot receive. For example, $1,000 per week may not be as high as 70 percent of your salary. In this case, you may wish to consider electing a lower percentage of coverage.

When you become disabled, the first day of your disability is considered your disability onset date. You are required to use all Family/Medical Leave (FML) or sick leave before STD payments begin. There is an elimination period of either 21 consecutive days from the date of onset of your disability or of the time by which all FML/sick leave is exhausted, whichever is later. The 21-day elimination period is part of the 26-week duration period.

During the elimination period, if you do not have enough FML/sick leave to cover the entire 21 days, you must use available PTO/vacation time through the 21-day period. After the elimination period is exhausted, you may request to use some, all or none of your PTO/vacation leave.

However, if you request to use PTO/vacation time, this time will reduce the 26-week duration period. Additionally, any partial disability payment periods or intermittent periods of work where you do not return to work for more than 30 consecutive calendar days at 100 percent of your job's regular hours will also reduce the 26-week duration period.

If your claim is related to a mental health diagnosis, VPA, Inc. will work with UBH to ensure that you receive a disability assessment and care by a licensed mental health professional and that you are assigned a care coordinator who will regularly work with you, VPA, Inc. and your mental health provider on your treatment plan and your return-to-work goals.

The STD benefit includes a return-to-work incentive designed to lessen the financial hardship that your disability caused by allowing you to return to work on a part-time basis within your restrictions and limitations. Your STD benefit continues to be paid, within certain limits, in addition to your part-time earnings.

The weekly STD benefit is limited to 80 percent of your pre-disability gross earnings when your part-time earnings are added to your STD weekly benefit. If your weekly STD benefit and your part-time earnings exceed 80 percent of your pre-disability earnings, your STD benefit will be reduced so that the total amount of the gross part-time earnings and your STD benefit equals the lesser of your standard STD benefit or 80 percent of your pre-disability wage. Refer to the STD Summary Plan Document for an example of this calculation.

The return-to-work incentive begins the first day you return to part-time work. The incentive continues for a period of up to 21 weeks until you stop working part-time and are completely disabled or until you are no longer disabled, whichever occurs first. Refer to the STD Summary Plan Document for details.

Your benefit will be reduced by any income that you receive, including, but not limited to:

- County-provided PTO/FML (vacation/sick pay for courts)
- County-paid donated leave
- Any workers' compensation payments, including income protection
- All retirement or disability benefits from any state or government plan
- Any benefits or payments you are eligible to receive for disability or loss of time or income to which the employer, trade or professional organization directly or indirectly sponsored or contributed.

- All veterans disability pension benefits, if received for the same disability
- No-fault insurance award or third-party subrogation

If you are disabled, return to work and become disabled again due to the same or a related cause, the second disability will be considered a continuation of the first period of disability if you returned to work for less than 30 consecutive calendar days. If the second disability is unrelated to the first, or if you returned to work for more than 30 days, the second period of disability will be considered a separate claim and a new elimination period must be satisfied before benefits become payable.

MARIFLEX FLEXIBLE SPENDING ACCOUNTS

SPONSORED BY MARICOPA COUNTY AND ADMINISTERED BY APPLICATION SOFTWARE, INC. (ASI)

GROUP NUMBER: 455

SPENDING ACCOUNT OVERVIEW

A Flexible Spending Account (FSA) is a benefit provided by Maricopa County that allows you to deposit a certain amount of your paycheck into an account before paying income taxes. Then, during the year, you can be directly reimbursed from this account for eligible health care and/or dependent care expenses.

THERE ARE TWO TYPES OF FSAS: A HEALTH CARE ACCOUNT USED FOR OUT-OF-POCKET (OOP) HEALTH CARE EXPENSES AND A DEPENDENT CARE ACCOUNT USED FOR DEPENDENT CARE EXPENSES THAT ENABLE YOU AND YOUR SPOUSE, IF APPLICABLE, TO WORK.

When you elect to participate in the health and/or dependent care FSA, under IRS rules you are asking Maricopa County to reduce your taxable income in exchange for a before-tax benefit. Therefore, your contributions reduce what is reported as income on your W-2 form. Your contributions are not subject to Medicare, OASDI or federal and state income taxes. The result is that you pay no tax on the amount you contribute. The net effect to you is lower health care and/or dependent care expenses.

Can I participate in a health care account even if I am not covered under my company's health insurance plan?

Yes. OOP expenses, whether incurred by you, your spouse or any dependent you claim on your income tax return, are eligible for reimbursement from your health care account whether you or they are insured through Maricopa County's health insurance plan.

How do I make deposits into a health care or dependent care spending account?

When you enroll in the FSA, you estimate the amount of dependent care and/or health care expenses you will incur during the year. You have this sum deducted from your paychecks in equal amounts throughout the year.

How much may I contribute to a health care spending account each year?

You may contribute up to $5,200 each year.

What types of expenses can be reimbursed from a health care spending account?

Eligible expenses, defined in Section 213 of the IRC, are those not paid for by any insurance, and do not include insurance premiums, long-term care expenses and expenses incurred for strictly cosmetic procedures. Refer to IRS Publication 502 for additional information. The list below includes some, but not all, eligible expenses:

- Health care plan deductibles, copayments and coinsurance
- Amounts over the maximum your plan pays
- Certain over-the-counter medications purchased to treat an existing or imminent medical condition, such as allergy or smoking cessation medications
- Eye exams, contact lenses, contact lens solution, glasses and LASIK surgery
- Dental exams, cleaning, fillings, crowns and braces
- Chiropractic care

- Prescription drugs and insulin
- Hearing aids and exams
- Mileage to and from medical appointments
- Treatment for obesity (including Weight Watchers meeting fees)

For a list of eligible and ineligible expenses, refer to the Mariflex plan summary on the Benefits Home Page or contact ASI. Some expenses require documentation from your physician.

Can I use my health care spending account for over-the-counter (OTC) medications?

You may use your health care spending account for some OTC medications taken to treat an injury or illness. For more information on OTC medications, refer to the ASI Over-the-Counter Medicines and Drugs Flex News flier at the Mariflex link on the Benefits Home Page or contact ASI.

What are ineligible expenses for my health care spending account?

Ineligible expenses include, but are not limited to, health and dental insurance premiums and cosmetic-related surgery. For the list of eligible expenses, refer to the Mariflex Plan Document on the Benefits Home Page or contact ASI.

How much may I contribute to a dependent care account each year?

Each year you may contribute a maximum of:

- $5,000 if you are single, or you are married and you and your spouse file a joint federal income tax return, or
- $2,500 if you are married and you and your spouse file individual federal income tax returns.

What expenses are eligible for reimbursement under the dependent care account?

Eligible expenses include services provided:

- Inside or outside your home by anyone other than your spouse, a person you list as your dependent for income tax purposes or one of your children under the age of 19.
- In a dependent care or child care center. If the child care center cares for more than six children, it must comply with all applicable state and local regulations.
- By a housekeeper whose services include, in part, providing care for a qualifying individual.
- Through adult or child day care, including nursery, pre-school, after-school or summer day camp programs. Taxes you pay on wages for eligible dependent care also can be reimbursed.
- By a provider who does not intend to claim the income as earnings. The provider's Social Security or tax ID number and payment/services details must be included with your federal income tax return on Form 2441. As a result, your provider will have to pay taxes on that income.

Who is eligible as a dependent under the dependent care account?

- Your dependent under age 13 for whom you can claim an exemption;
- A child under 13 of whom you have custody if you are divorced or legally separated;
- Your spouse who is physically or mentally incapable of self-care;
- Your dependent who is physically or mentally incapable of self-care.

Refer to IRS publication 503 for more information.

What are ineligible expenses for my dependent care account?

Ineligible expenses include dependent care for a child 13 or older, overnight camp, baby-sitting that is not work-related, costs associated with attending kindergarten and higher grades, and long-term care services.

Can I use the federal dependent care credit if I have a FSA dependent care account?

No. You may use only one or the other, but not both.

When do health care or dependent care expenses have to be incurred to be eligible?

Expenses must be incurred during each plan year from your effective date of eligibility. You have 90 days after the end of the plan year to submit claim forms for reimbursement. If you do not use all of your contributions, the remaining balance will not be refunded to you or carried forward to the next plan year.

What happens if I miss some FSA payments when I'm on a leave of absence?

If you miss some payments, upon your return to work, the pay period deduction amount will be recalculated based on your annual pledge minus your year-to-date contributions divided by the number of pay periods remaining in the calendar year. Claim forms, the plan summary, a direct deposit form and a link to the home page of the Mariflex administrator, ASI, are available through the Benefits Home Page by clicking on the Mariflex link. Assistance is also available by calling ASI Customer Service at 1-800-659-3035, Monday through Friday, 7 a.m.-7

p.m. CST, visiting the Web site at www.asiflex.com or by e-mailing asi@asiflex.com. Before enrolling, please refer to the full plan summary and associated IRS publications for more specific information regarding plan limitations and exclusions.

Is a debit card available with the FSA?

The FSA offers a debit card that can be used to pay your pharmacy claims at the time of service at certain pharmacies. A small monthly fee applies. Enrollment information is included with the ASI information packet that you will receive after your enrollment information is sent to ASI.

MARIFLEX EXAMPLE

IMPROVE YOUR SMILE ... TAX FREE

By enrolling in a Mariflex health care FSA, you can set aside money to reimburse yourself for out-of-pocket (OOP) medical and dental expenses, including orthodontics, with before-tax salary dollars. Now that's something to smile about.

In the example below, your tax savings will be approximately $693 annually by using a health care FSA.

Filing Status: Single with one dependent

	With Mariflex	Without Mariflex
Annual Income:	$35,000	$35,000
Estimated Health Care Expenses:	- $2,000	- $0
Estimated Dependent Care Expenses:	- $0	- $0
Taxable Income:	= $33,000	= $35,000
Estimated Federal Income Tax:	- $4,345	- $4,845
Estimated Social Security Tax:	- $2,524	- $2,677
Health Care Expenses:	- $0	- $2,000
Dependent Care Expenses:	- $0	- $0
Tax Credit For Dependent Care:	+ $0	+ $0
Net Pay:	= $26,131	= $25,478

This illustration is an example of potential federal tax savings based on a gross annual income of $35,000 and does not pertain to any individual tax situation. You may receive additional tax savings from state and local taxes. Consult your tax advisor for more information.

ADDITIONAL BENEFITS

A brief summary of additional benefits is provided below. For detailed information, please access the Benefits Home Page on the EBC/Intranet at ebc.maricopa.gov/hr/benefits or on the Internet at www.maricopa.gov/benefits.

AUTO, HOME AND RENTERS INSURANCE

PROVIDED BY LIBERTY MUTUAL

As a Maricopa County employee, you qualify for a special group discount* on your auto, home and renters insurance through Group Savings Plus® from Liberty Mutual. With Group Savings Plus, you can enjoy the ease and convenience of paying your premiums through payroll or checking account deductions, with no down payment or finance charges. You also will enjoy fast, easy, round-the-clock claims service and a variety of discounts for multi-car, multi-policy, safe-driver, passive restraints and anti-theft devices. *

See for yourself how much money you could save with Liberty Mutual compared with your current insurance provider. For a free, no-obligation quote, call 1-800-221-8135 or visit www.libertymutual.com/lm/maricopafcu to request an online quote. You can also visit the Web site to learn more about Liberty Mutual.

*Group discounts, other discounts and credits are available where state laws and regulations allow, and may vary by state. Certain discounts apply to specific coverage only. To the extent permitted by law, applicants are individually underwritten; not all applicants may qualify. Coverage is provided and underwritten by Liberty Mutual Insurance Company and its affiliates, 175 Berkeley Street, Boston, MA.

CRITICAL ILLNESS COVERAGE

PROVIDED BY TRUSTMARK

Premier Protector Critical Illness Insurance

Protecting the lifestyle and financial security of our employees is a primary consideration in decisions made by Maricopa County. We recognize that each employee's family situation and insurance needs are different.

With these goals in mind, Maricopa County offers a supplemental critical illness insurance plan, underwritten by Trustmark Insurance Company. This benefit is available to you and your dependents on a group basis through the convenience of payroll deduction.

Trustmark's Premier Protector Critical Illness Insurance pays a lump-sum amount upon the initial diagnosis of any covered critical illness. The plan is designed to cover indirect expenses associated with a critical illness, including the loss of income, deductibles and copayments/coinsurance, alternative treatments, meals and lodging, out-of-network treatments, home recovery, family care and living expenses.

Trustmark's Premier Protector Critical Illness Insurance complements existing benefits and enables you to customize an insurance package to meet your specific needs. This plan is appropriate for single as well as married individuals and, unlike traditional group insurance, may be continued upon termination of employment at no increased cost.

For additional information or to enroll, please contact Einstein Benefit Communications at:

- Enrollment Services: (480) 991-4444, ext. 15
- Enrollment Fax: (480) 596-9833
- E-mail: enrollment@einsteinbenefit.com

DEFERRED COMPENSATION

ADMINISTERED BY NATIONWIDE RETIREMENT SOLUTIONS

To enhance your future, Maricopa County, in partnership with **Nationwide Retirement Solutions (NRS)**, offers you one of the best deferred compensation plans in the country.

The pension plan was not designed to provide your entire retirement income, which is why participating in a deferred compensation program is such an essential step to achieving financial independence upon retirement.

TAX DEFERRED INVESTING

A deferred compensation program allows you to contribute money, before it is taxed, to an account. This means that you do not have to pay income tax on the money you contribute until you retire and withdraw the money. Postponing the payment of income tax on your contributions gives your money time to grow over the years.

When you withdraw monies from your deferred compensation account, typically during retirement, you will have to pay associated taxes. However, tax is paid only on the amount(s) you withdraw in a given year. Meanwhile, the rest of your investment has the opportunity to continue to grow tax deferred.

THE IMPACT OF DEFERRED COMPENSATION ON YOUR PAYCHECK

A single person with one deduction earning $1,250 gross every two weeks can save $50 in an after-tax savings account and take-home pay of $850. If that same $50 was invested in a tax deferred program, the take-home pay would increase to $864 — an extra $28 a month, or $364 a year.

	Regular savings (after tax)	Deferred compensation (pre-tax)
Gross pay (bi-weekly)	$1,250	$1,250
Amount saved/contributed	$50	$50
Taxable income	$1,250	$1,200
Taxes	$350	$336
Take-home pay	$850	$864
Additional dollars in your paycheck	$0	$14 per paycheck, or $364 annually

Assumes 28% federal and withholding income tax rate and bi-weekly pay periods.

PARTICIPATION IS EASY

Once you enroll, contributions are deducted from your paycheck through payroll deduction. You can easily make changes to the amount of your contribution at any time during the year as your personal situation and needs change.

DETERMINING HOW MUCH TO INVEST

How much should you contribute? There is no easy answer to this question, but the best general answer is "as much as you can." A more accurate answer depends on multiple variables, including the amount you might receive from a retirement pension and from Social Security, the amount of interest your investments earn between now and the time you retire and the standard of living you want at retirement. Regardless of how much you can afford to contribute, the sooner you join the deferred compensation plan, the greater the benefit to you. You should participate as soon as you can to give your investments as much time as possible to grow.

The minimum contribution amount is $10 per pay period. The maximum contribution amount is 100 percent of includible compensation, up to $14,000 for 2005 and $15,000 for 2006 if you are under 50.

If you are 50 or older in this calendar year, the catch-up provision allows you to contribute a maximum of $18,000 in 2005 and $20,000 in 2006.

If you are within three years of retirement, you may qualify to contribute up to $26,000 for 2005 and therefore have past dollars to “catch up.”

DETERMINING WHERE TO INVEST

You can choose from a variety of investment options when you start contributing to your deferred compensation account. Use the **Ibbotson Asset Allocation Tool** included in the Planning Tools section of the Nationwide Retirement Solutions (NRS) Web site under Investment Education to help you determine the investment options appropriate for you. Licensed and trained NRS Retirement Specialists can provide personalized assistance with your retirement needs in person.. These specialists are not paid on a commission basis. Their role is to educate employees regarding the deferred compensation benefit.

Retirement Specialists are also available to you through a unique service called Direct Access. NRS has teamed with Ibbotson Associates, one of the nation’s premier providers on investment modeling, to introduce a new program based on an Ibbotson asset allocation model, a tool designed to help you decide what type of an investor you are. In addition, you have access to a helpful online tool, Morningstar Clear Future, which provides investment guidance, planning, and education – all directed at helping you formulate an appropriate investment strategy for your individual situation.

NRS offers a wide range of investment options to serve every investor’s needs. Nationwide also offers a Personal Choice Retirement Account (PCRA), in conjunction with Charles Schwab, that allows you to invest in stocks, mutual funds and a variety of other securities not offered through their core program. Their core program offers funds that include the fund families of Vanguard, American Century, Putnam, Janus, Fidelity and INVESCO.

WITHDRAWAL OF FUNDS

There are three different withdrawal options:

1. At the time of separation of service. There is no penalty for withdrawal before age 59 ½.
2. For a financial hardship as defined by the IRS.
3. Loan provision. Borrow up to 50 percent of the value of your account with a minimum of $1,000.

ENROLLMENT AND SERVICE OPTIONS

- Contact NRS at 602-266-2733 to request a personal visit with a retirement specialist.
- Call customer service: 1-800-598-4457
- Visit the Web site: www.maricopadc.com
- Walk-in service: 4747 N. 7th St., #418, Phoenix, AZ 85014

2005 PREMIUM RATES FOR
MARICOPA COUNTY EMPLOYEES

Payroll deductions for the insurance plans will be made from the first two paychecks of the month, 24 paychecks per year. Only the Mariflex flexible spending accounts will be deducted from all 26 paychecks per year. Actual premium deduction may vary by one or two cents due to rounding.

HEALTHSELECT RATES

All HealthSelect plan premiums include coverage for medical, pharmacy, behavioral health and substance abuse, vision, wellness and benefit contracts. Medical coverage is provided by Maricopa County and administered by CIGNA; pharmacy coverage is provided by Maricopa County and administered by WHI; behavioral health and substance abuse coverage is provided by UBH; vision coverage is provided by Avesis, and wellness coverage is provided by Maricopa County.

HEALTHSELECT HIGH OPTION MEDICAL PLAN WITH COINSURANCE RX PLAN

	FULL-TIME		**PART-TIME**	
	30 hours or more per week		Between 20-29.99 hours per week	
	County Contribution Per Payday	Employee Cost Per Payday	County Contribution Per Payday	Employee Cost Per Payday
Employee	$159.88	***$2.50***	$159.88	***$2.50***
Employee and Spouse	$268.02	***$39.90***	$268.02	***$39.90***
Employee and Child(ren)	$229.34	***$27.48***	$229.34	***$27.48***
Employee and Family	$331.06	***$60.36***	$331.06	***$60.36***

HEALTHSELECT HIGH OPTION MEDICAL PLAN WITH CONSUMER CHOICE RX PLAN

	FULL-TIME		**PART-TIME**	
	30 hours or more per week		Between 20-29.99 hours per week	
	County Contribution Per Payday	Employee Cost Per Payday	County Contribution Per Payday	Employee Cost Per Payday
Employee	$157.88	***$2.00***	$157.88	***$2.00***
Employee and Spouse	$268.02	***$34.88***	$268.02	***$34.88***
Employee and Child(ren)	$229.34	***$23.36***	$229.34	***$23.36***
Employee and Family	$331.06	***$53.72***	$331.06	***$53.72***

HEALTHSELECT LOW OPTION MEDICAL PLAN WITH COINSURANCE RX PLAN

	FULL-TIME		**PART-TIME**	
	30 hours or more per week		Between 20-29.99 hours per week	
	County Contribution Per Payday	Employee Cost Per Payday	County Contribution Per Payday	Employee Cost Per Payday
Employee	$135.32	***$1.50***	$135.32	***$1.50***
Employee and Spouse	$239.02	***$20.86***	$239.02	***$20.86***
Employee and Child(ren)	$200.76	***$16.28***	$200.76	***$16.28***
Employee and Family	$288.62	***$42.80***	$288.62	***$42.80***

HEALTHSELECT LOW OPTION MEDICAL PLAN WITH CONSUMER CHOICE RX PLAN

	FULL-TIME		**PART-TIME**	
	30 hours or more per week		Between 20-29.99 hours per week	
	County Contribution Per Payday	Employee Cost Per Payday	County Contribution Per Payday	Employee Cost Per Payday
Employee	$134.32	***$0.00***	$134.32	***$0.00***
Employee and Spouse	$239.02	***$15.84***	$239.02	***$15.84***
Employee and Child(ren)	$200.76	***$12.16***	$200.76	***$12.16***
Employee and Family	$288.62	***$36.16***	$288.62	***$36.16***

CIGNA RATES

All CIGNA plan premiums include coverage for medical, pharmacy, behavioral health and substance abuse, vision, wellness, contract performance, external prosthetic appliance and benefit contracts. Medical coverage is provided by CIGNA; pharmacy coverage is provided by Maricopa County and administered by WHI; behavioral health and substance abuse coverage is provided by UBH, except for the low option PPO plan which is provided by CIGNA Behavioral Health; vision coverage is provided by Avesis, and wellness coverage is provided by Maricopa County.

CIGNA HEALTH MAINTENANCE ORGANIZATION (HMO) RATES

CIGNA HMO HIGH OPTION MEDICAL PLAN WITH COINSURANCE RX PLAN

	FULL-TIME		**PART-TIME**	
	30 hours or more per week		Between 20-29.99 hours per week	
	County Contribution Per Payday	Employee Cost Per Payday	County Contribution Per Payday	Employee Cost Per Payday
Employee	$185.86	***$8.06***	$100.80	***$93.12***
Employee and Spouse	$336.74	***$47.22***	$283.02	***$100.94***
Employee and Child(ren)	$284.50	***$33.66***	$219.94	***$98.22***
Employee and Family	$435.86	***$73.06***	$402.76	***$106.16***

CIGNA HMO HIGH OPTION MEDICAL PLAN WITH CONSUMER CHOICE RX PLAN

	FULL-TIME		**PART-TIME**	
	30 hours or more per week		Between 20-29.99 hours per week	
	County Contribution Per Payday	Employee Cost Per Payday	County Contribution Per Payday	Employee Cost Per Payday
Employee	$185.86	***$5.48***	$100.30	***$91.04***
Employee and Spouse	$336.74	***$42.06***	$279.98	***$98.82***
Employee and Child(ren)	$284.50	***$29.40***	$217.78	***$96.12***
Employee and Family	$435.86	***$66.22***	$398.08	***$104.00***

CIGNA HMO LOW OPTION MEDICAL PLAN WITH COINSURANCE RX PLAN

	FULL-TIME		**PART-TIME**	
	30 hours or more per week		Between 20-29.99 hours per week	
	County Contribution Per Payday	Employee Cost Per Payday	County Contribution Per Payday	Employee Cost Per Payday
Employee	$153.28	***$2.98***	$80.94	***$75.32***
Employee and Spouse	$279.16	***$29.48***	$224.66	***$83.98***
Employee and Child(ren)	$235.88	***$20.38***	$175.28	***$80.98***
Employee and Family	$362.14	***$47.00***	$319.38	***$89.76***

CIGNA HMO LOW OPTION MEDICAL PLAN WITH CONSUMER CHOICE RX PLAN

	FULL-TIME		**PART-TIME**	
	30 hours or more per week		Between 20-29.99 hours per week	
	County Contribution Per Payday	Employee Cost Per Payday	County Contribution Per Payday	Employee Cost Per Payday
Employee	$153.28	***$0.40***	$79.58	***$74.10***
Employee and Spouse	$279.16	***$24.32***	$220.76	***$82.72***
Employee and Child(ren)	$235.88	***$16.12***	$172.28	***$79.72***
Employee and Family	$362.14	***$40.16***	$313.86	***$88.44***

CIGNA POINT-OF-SERVICE (POS) RATES

CIGNA POS HIGH OPTION MEDICAL PLAN WITH COINSURANCE RX PLAN

	FULL-TIME		PART-TIME	
	30 hours or more per week		Between 20-29.99 hours per week	
	County Contribution Per Payday	Employee Cost Per Payday	County Contribution Per Payday	Employee Cost Per Payday
Employee	$185.86	***$13.86***	$100.80	***$98.92***
Employee and Spouse	$336.74	***$58.92***	$283.02	***$112.64***
Employee and Child(ren)	$284.50	***$43.32***	$219.94	***$107.88***
Employee and Family	$435.86	***$88.54***	$402.76	***$121.64***

CIGNA POS HIGH OPTION MEDICAL PLAN WITH CONSUMER CHOICE RX PLAN

	FULL-TIME		PART-TIME	
	30 hours or more per week		Between 20-29.99 hours per week	
	County Contribution Per Payday	Employee Cost Per Payday	County Contribution Per Payday	Employee Cost Per Payday
Employee	$185.86	***$11.14***	$100.30	***$96.70***
Employee and Spouse	$336.74	***$53.48***	$279.98	***$110.24***
Employee and Child(ren)	$284.50	***$38.84***	$217.78	***$105.56***
Employee and Family	$435.86	***$81.34***	$398.08	***$119.12***

CIGNA POS LOW OPTION MEDICAL PLAN WITH COINSURANCE RX PLAN

	FULL-TIME		PART-TIME	
	30 hours or more per week		Between 20-29.99 hours per week	
	County Contribution Per Payday	Employee Cost Per Payday	County Contribution Per Payday	Employee Cost Per Payday
Employee	$147.36	***$10.96***	$80.94	***$77.38***
Employee and Spouse	$266.32	***$46.54***	$224.66	***$88.20***
Employee and Child(ren)	$225.48	***$34.28***	$175.28	***$84.48***
Employee and Family	$344.76	***$69.96***	$319.38	***$95.34***

CIGNA POS LOW OPTION MEDICAL PLAN WITH CONSUMER CHOICE RX PLAN

	FULL-TIME		PART-TIME	
	30 hours or more per week		Between 20-29.99 hours per week	
	County Contribution Per Payday	Employee Cost Per Payday	County Contribution Per Payday	Employee Cost Per Payday
Employee	$153.26	***$2.34***	$79.58	***$76.02***
Employee and Spouse	$279.18	***$28.24***	$220.76	***$86.66***
Employee and Child(ren)	$235.88	***$19.40***	$172.28	***$83.00***
Employee and Family	$362.14	***$45.38***	$313.86	***$93.66***

CIGNA PREFERRED PROVIDER ORGANIZATION (PPO) RATES

CIGNA PPO HIGH OPTION MEDICAL PLAN WITH COINSURANCE RX PLAN

	FULL-TIME		**PART-TIME**	
	30 hours or more per week		Between 20-29.99 hours per week	
	County Contribution Per Payday	Employee Cost Per Payday	County Contribution Per Payday	Employee Cost Per Payday
Employee	$184.16	***$77.42***	$99.10	***$162.48***
Employee and Spouse	$335.04	***$185.90***	$281.32	***$239.62***
Employee and Child(ren)	$282.80	***$148.04***	$218.24	***$212.60***
Employee and Family	$434.16	***$256.90***	$401.06	***$290.00***

CIGNA PPO HIGH OPTION MEDICAL PLAN WITH CONSUMER CHOICE RX PLAN

	FULL-TIME		**PART-TIME**	
	30 hours or more per week		Between 20-29.99 hours per week	
	County Contribution Per Payday	Employee Cost Per Payday	County Contribution Per Payday	Employee Cost Per Payday
Employee	$184.16	***$74.12***	$96.90	***$161.38***
Employee and Spouse	$335.04	***$179.32***	$276.58	***$237.78***
Employee and Child(ren)	$282.80	***$142.60***	$214.38	***$211.02***
Employee and Family	$434.16	***$248.16***	$394.68	***$287.64***

CIGNA PPO LOW OPTION MEDICAL PLAN WITH COINSURANCE RX PLAN

	FULL-TIME		**PART-TIME**	
	30 hours or more per week		Between 20-29.99 hours per week	
	County Contribution Per Payday	Employee Cost Per Payday	County Contribution Per Payday	Employee Cost Per Payday
Employee	$184.16	***$55.36***	$90.74	***$148.78***
Employee and Spouse	$335.04	***$141.76***	$257.48	***$219.32***
Employee and Child(ren)	$282.80	***$111.72***	$199.84	***$194.68***
Employee and Family	$434.16	***$198.40***	$367.10	***$265.46***

CIGNA PPO LOW OPTION MEDICAL PLAN WITH CONSUMER CHOICE RX PLAN

	FULL-TIME		**PART-TIME**	
	30 hours or more per week		Between 20-29.99 hours per week	
	County Contribution Per Payday	Employee Cost Per Payday	County Contribution Per Payday	Employee Cost Per Payday
Employee	$184.16	***$52.06***	$88.62	***$147.60***
Employee and Spouse	$335.04	***$135.18***	$252.84	***$217.38***
Employee and Child(ren)	$282.80	***$106.28***	$196.08	***$193.00***
Employee and Family	$434.16	***$189.66***	$360.84	***$262.98***

DENTAL PLANS

EMPLOYERS DENTAL SERVICES (EDS)

A Managed Care Dental Organization

	FULL-TIME		PART-TIME	
	30 hours or more per week		Between 20-29.99 hours per week	
	County Contribution Per Payday	Employee Cost Per Payday	County Contribution Per Payday	Employee Cost Per Payday
Employee	$2.62	***$1.98***	$2.62	***$1.98***
Employee and Spouse	$4.98	***$3.76***	$4.98	***$3.76***
Employee and Child(ren)	$6.52	***$4.94***	$6.52	***$4.94***
Employee and Family	$7.52	***$5.68***	$7.52	***$5.68***

UNITED CONCORDIA

A PPO Dental Plan

	FULL-TIME		PART-TIME	
	30 hours or more per week		Between 20-29.99 hours per week	
	County Contribution Per Payday	Employee Cost Per Payday	County Contribution Per Payday	Employee Cost Per Payday
Employee	$8.24	***$6.24***	$4.12	***$10.36***
Employee and Spouse	$18.14	***$13.80***	$8.30	***$23.64***
Employee and Child(ren)	$19.64	***$14.90***	$10.12	***$24.42***
Employee and Family	$25.22	***$19.18***	$12.14	***$32.26***

AVESIS VISION STAND ALONE OPTION

Available only if enrolling for the medical waiver payment
100% Paid by Employee

	Employee Cost Per Payday
Employee	***$3.42***
Employee and Spouse	***$6.46***
Employee and Child(ren)	***$7.04***
Employee and Family	***$9.06***

SHORT-TERM DISABILITY PLAN

100% Paid by Employee
$1,000 weekly maximum

Short-Term Disability Options	Rate Multiplier for 24 Pay Periods
40% of Biweekly Base Salary*	$0.0035
50% of Biweekly Base Salary*	$0.0050
60% of Biweekly Base Salary*	$0.0065
70% of Biweekly Base Salary*	$0.0080

SHORT-TERM DISABILITY EXAMPLE

Base Annual Salary: $25,000

Base Annual Salary divided by 12 months = Monthly Salary	**$25,000 / 12 = $2,083.33**			
Base Monthly Salary: **$2,083.33**	**40% Option**	**50% Option**	**60% Option**	**70% Option**
Monthly Contribution = Base Monthly Salary (up to Maximum Base Monthly Salary) multiplied by Rate Multiplier	$2,083.33 X 0.0035	$2,083.33 X 0.0050	$2,083.33 X 0.0065	$2,083.33 X 0.0080
Monthly Contribution	**$7.29**	**$10.42**	**$13.54**	**$16.67**
Pay Period Contribution = Monthly Premium divided by 2	$3.65	$5.21	$6.77	$8.33

**Up to maximum benefit coverage*

LIFE INSURANCE

BASIC LIFE WITH ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D)
1 Times Base Salary – 100% Paid by Maricopa County

SUPPLEMENTAL LIFE WITH ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D)
1 to 5 Times Base Salary – 100% Paid by Employee

Supplemental Life Insurance Table

5 Year Age Categories	Employee Cost per Payday Per $1,000 of Coverage	Employee Cost per Payday Per $1,000 of Coverage
	Smoker Multiplier	***Non-Smoker Multiplier***
Under 25	$0.0475	$0.0340
25-29	$0.0500	$0.0380
30-34	$0.0540	$0.0460
35-39	$0.0855	$0.0500
40-44	$0.1170	$0.0620
45-49	$0.2195	$0.1015
50-54	$0.3935	$0.1765
55-59	$0.4005	$0.2240
60-64	$0.6125	$0.3725
65-69	$0.7475	$0.5225
70 and older	$1.2175	$0.9575

Supplemental Life Insurance Example

1. Take your annual base salary – **Example: $24,500**

2. Round **up** to the nearest $1,000 and then multiply	1 X Salary	2 X Salary	3 X Salary	4 X Salary	5 X Salary
	$25,000	$50,000	$75,000	$100,000	$125,000
3. Take the Salary amount and divide by $1,000	25	50	75	100	125

4. Refer to the Supplemental Life Insurance table above to find your age category and cost multiplier
5. Multiply the results from the calculation in Step 3 by the multiplier.

Example: Age 37	***Multiplier for Smoking***	***Multiplier for Non-Smoking***	***Coverage Amount***
	$0.085500	***$0.050000***	
1 X Salary	$0.0855 X 25 = $2.14	$0.0500 X 25 = $1.25	$25,000
2 X Salary	$0.0855 X 50 = $4.28	$0.0500 X 50 = $2.50	$50,000
3 X Salary	$0.0855 X 75 = $6.41	$0.0500 X 75 = $3.75	$75,000
4 X Salary	$0.0855 X 100 = $8.55	$0.0500 X 100 = $5.00	$100,000
5 X Salary	$0.0855 X 125 = $10.69	$0.0500 X 125 = $6.25	$125,000

DEPENDENT LIFE INSURANCE
100% Paid by Employee

	Option One	Option Two
Spouse	$5,000	$10,000
Children, live birth to 14 days	$1,000	$1,000
14 days to 19 years, 25 years if full-time student	$2,500	$5,000
Employee Cost Per Payday:	***$0.92***	***$1.84***

You must have a qualified status change as defined by the Internal Revenue Code, Section 125, in order to change your medical, dental or Mariflex flexible spending accounts after the closing date of the Open Enrollment period. No changes to your Short-Term Disability election will be allowed other than during open enrollment, even if you have a qualified status change.

2005 PREMIUM RATES FOR
SPECIAL HEALTH CARE DISTRICT EMPLOYEES

Payroll deductions for the insurance plans will be made from the first two paychecks of the month, 24 paychecks per year. Only the Mariflex flexible spending accounts will be deducted from all 26 paychecks per year. Actual premium deduction may vary by one or two cents due to rounding.

HEALTHSELECT RATES

All HealthSelect plan premiums include coverage for medical, pharmacy, behavioral health and substance abuse, vision, wellness and benefit contracts. Medical coverage is provided by Maricopa County and administered by CIGNA; pharmacy coverage is provided by Maricopa County and administered by WHI; behavioral health and substance abuse coverage is provided by UBH; vision coverage is provided by Avesis, and wellness coverage is provided by Maricopa County.

HEALTHSELECT HIGH OPTION MEDICAL PLAN WITH COINSURANCE RX PLAN

	FULL-TIME		**PART-TIME**	
	30 hours or more per week		Between 20-29.99 hours per week	
	District Contribution Per Payday	Employee Cost Per Payday	District Contribution Per Payday	Employee Cost Per Payday
Employee	$167.98	***$2.50***	$167.98	***$2.50***
Employee and Spouse	$283.36	***$39.90***	$283.36	***$39.90***
Employee and Child(ren)	$242.18	***$27.48***	$242.18	***$27.48***
Employee and Family	$350.62	***$60.36***	$350.62	***$60.36***

HEALTHSELECT HIGH OPTION MEDICAL PLAN WITH CONSUMER CHOICE RX PLAN

	FULL-TIME		**PART-TIME**	
	30 hours or more per week		Between 20-29.99 hours per week	
	District Contribution Per Payday	Employee Cost Per Payday	District Contribution Per Payday	Employee Cost Per Payday
Employee	$165.86	***$2.00***	$165.86	***$2.00***
Employee and Spouse	$283.12	***$34.88***	$283.12	***$34.88***
Employee and Child(ren)	$241.96	***$23.36***	$241.96	***$23.36***
Employee and Family	$350.28	***$53.72***	$350.28	***$53.72***

HEALTHSELECT LOW OPTION MEDICAL PLAN WITH COINSURANCE RX PLAN

	FULL-TIME		**PART-TIME**	
	30 hours or more per week		Between 20-29.99 hours per week	
	District Contribution Per Payday	Employee Cost Per Payday	District Contribution Per Payday	Employee Cost Per Payday
Employee	$142.14	***$1.50***	$142.14	***$1.50***
Employee and Spouse	$251.96	***$20.86***	$251.96	***$20.86***
Employee and Child(ren)	$211.60	***$16.28***	$211.60	***$16.28***
Employee and Family	$305.20	***$42.80***	$305.20	***$42.80***

HEALTHSELECT LOW OPTION MEDICAL PLAN WITH CONSUMER CHOICE RX PLAN

	FULL-TIME		**PART-TIME**	
	30 hours or more per week		Between 20-29.99 hours per week	
	District Contribution Per Payday	Employee Cost Per Payday	District Contribution Per Payday	Employee Cost Per Payday
Employee	$141.02	***$0.00***	$141.02	***$0.00***
Employee and Spouse	$251.72	***$15.84***	$251.72	***$15.84***
Employee and Child(ren)	$211.38	***$12.16***	$211.38	***$12.16***
Employee and Family	$304.86	***$36.16***	$304.86	***$36.16***

CIGNA RATES

All CIGNA plan premiums include coverage for medical, pharmacy, behavioral health and substance abuse, vision, wellness, contract performance, external prosthetic appliance and benefit contracts. Medical coverage is provided by CIGNA; pharmacy coverage is provided by Maricopa County and administered by WHI; behavioral health and substance abuse coverage is provided by UBH, except for the low option PPO plan which is provided by CIGNA Behavioral Health; vision coverage is provided by Avesis, and wellness coverage is provided by Maricopa County.

CIGNA HEALTH MAINTENANCE ORGANIZATION (HMO) RATES

CIGNA HMO HIGH OPTION MEDICAL PLAN WITH COINSURANCE RX PLAN

	FULL-TIME		**PART-TIME**	
	30 hours or more per week		Between 20-29.99 hours per week	
	District Contribution Per Payday	Employee Cost Per Payday	District Contribution Per Payday	Employee Cost Per Payday
Employee	$202.94	***$8.06***	$117.88	***$93.12***
Employee and Spouse	$370.80	***$47.22***	$317.08	***$100.94***
Employee and Child(ren)	$312.60	***$33.66***	$248.04	***$98.22***
Employee and Family	$481.00	***$73.06***	$447.90	***$106.16***

CIGNA HMO HIGH OPTION MEDICAL PLAN WITH CONSUMER CHOICE RX PLAN

	FULL-TIME		**PART-TIME**	
	30 hours or more per week		Between 20-29.99 hours per week	
	District Contribution Per Payday	Employee Cost Per Payday	District Contribution Per Payday	Employee Cost Per Payday
Employee	$202.82	***$5.48***	$117.26	***$91.04***
Employee and Spouse	$370.54	***$42.06***	$313.78	***$98.82***
Employee and Child(ren)	$312.40	***$29.40***	$245.68	***$96.12***
Employee and Family	$480.66	***$66.22***	$442.88	***$104.00***

CIGNA HMO LOW OPTION MEDICAL PLAN WITH COINSURANCE RX PLAN

	FULL-TIME		**PART-TIME**	
	30 hours or more per week		Between 20-29.99 hours per week	
	District Contribution Per Payday	Employee Cost Per Payday	District Contribution Per Payday	Employee Cost Per Payday
Employee	$166.62	***$2.98***	$94.28	***$75.32***
Employee and Spouse	$305.72	***$29.48***	$251.22	***$83.98***
Employee and Child(ren)	$257.82	***$20.38***	$197.22	***$80.98***
Employee and Family	$397.34	***$47.00***	$354.58	***$89.76***

CIGNA HMO LOW OPTION MEDICAL PLAN WITH CONSUMER CHOICE RX PLAN

	FULL-TIME		**PART-TIME**	
	30 hours or more per week		Between 20-29.99 hours per week	
	District Contribution Per Payday	Employee Cost Per Payday	District Contribution Per Payday	Employee Cost Per Payday
Employee	$166.50	***$0.40***	$92.80	***$74.10***
Employee and Spouse	$305.46	***$24.32***	$247.06	***$82.72***
Employee and Child(ren)	$257.62	***$16.12***	$194.02	***$79.72***
Employee and Family	$397.00	***$40.16***	$348.72	***$88.44***

CIGNA POINT-OF-SERVICE (POS) RATES

CIGNA POS HIGH OPTION MEDICAL PLAN WITH COINSURANCE RX PLAN

	FULL-TIME		PART-TIME	
	30 hours or more per week		Between 20-29.99 hours per week	
	District Contribution Per Payday	Employee Cost Per Payday	District Contribution Per Payday	Employee Cost Per Payday
Employee	$218.76	***$13.86***	$133.70	***$98.92***
Employee and Spouse	$402.36	***$58.92***	$348.64	***$112.64***
Employee and Child(ren)	$338.58	***$43.32***	$274.02	***$107.88***
Employee and Family	$522.88	***$88.54***	$489.78	***$121.64***

CIGNA POS HIGH OPTION MEDICAL PLAN WITH CONSUMER CHOICE RX PLAN

	FULL-TIME		PART-TIME	
	30 hours or more per week		Between 20-29.99 hours per week	
	District Contribution Per Payday	Employee Cost Per Payday	District Contribution Per Payday	Employee Cost Per Payday
Employee	$218.64	***$11.14***	$133.08	***$96.70***
Employee and Spouse	$402.10	***$53.48***	$345.34	***$110.24***
Employee and Child(ren)	$338.36	***$38.84***	$271.64	***$105.56***
Employee and Family	$522.52	***$81.34***	$484.74	***$119.12***

CIGNA POS LOW OPTION MEDICAL PLAN WITH COINSURANCE RX PLAN

	FULL-TIME		PART-TIME	
	30 hours or more per week		Between 20-29.99 hours per week	
	District Contribution Per Payday	Employee Cost Per Payday	District Contribution Per Payday	Employee Cost Per Payday
Employee	$172.04	***$10.96***	$105.62	***$77.38***
Employee and Spouse	$315.48	***$46.54***	$273.82	***$88.20***
Employee and Child(ren)	$266.04	***$34.28***	$215.84	***$84.48***
Employee and Family	$409.96	***$69.96***	$384.58	***$95.34***

CIGNA POS LOW OPTION MEDICAL PLAN WITH CONSUMER CHOICE RX PLAN

	FULL-TIME		PART-TIME	
	30 hours or more per week		Between 20-29.99 hours per week	
	District Contribution Per Payday	Employee Cost Per Payday	District Contribution Per Payday	Employee Cost Per Payday
Employee	$177.82	***$2.34***	$104.14	***$76.02***
Employee and Spouse	$328.08	***$28.24***	$269.66	***$86.66***
Employee and Child(ren)	$276.22	***$19.40***	$212.62	***$83.00***
Employee and Family	$426.98	***$45.38***	$378.70	***$93.66***

CIGNA PREFERRED PROVIDER ORGANIZATION (PPO) RATES

CIGNA PPO HIGH OPTION MEDICAL PLAN WITH COINSURANCE RX PLAN

	FULL-TIME		**PART-TIME**	
	30 hours or more per week		Between 20-29.99 hours per week	
	District Contribution Per Payday	Employee Cost Per Payday	District Contribution Per Payday	Employee Cost Per Payday
Employee	$201.66	***$77.42***	$116.60	***$162.48***
Employee and Spouse	$369.94	***$185.90***	$316.22	***$239.62***
Employee and Child(ren)	$311.62	***$148.04***	$247.06	***$212.60***
Employee and Family	$480.46	***$256.90***	$447.36	***$290.00***

CIGNA PPO HIGH OPTION MEDICAL PLAN WITH CONSUMER CHOICE RX PLAN

	FULL-TIME		**PART-TIME**	
	30 hours or more per week		Between 20-29.99 hours per week	
	District Contribution Per Payday	Employee Cost Per Payday	District Contribution Per Payday	Employee Cost Per Payday
Employee	$201.50	***$74.12***	$114.24	***$161.38***
Employee and Spouse	$369.60	***$179.32***	$311.14	***$237.78***
Employee and Child(ren)	$311.36	***$142.60***	$242.94	***$211.02***
Employee and Family	$480.05	***$248.16***	$440.57	***$287.64***

CIGNA PPO LOW OPTION MEDICAL PLAN WITH COINSURANCE RX PLAN

	FULL-TIME		**PART-TIME**	
	30 hours or more per week		Between 20-29.99 hours per week	
	District Contribution Per Payday	Employee Cost Per Payday	District Contribution Per Payday	Employee Cost Per Payday
Employee	$200.08	***$55.36***	$106.66	***$148.78***
Employee and Spouse	$366.80	***$141.76***	$289.24	***$219.32***
Employee and Child(ren)	$309.04	***$111.72***	$226.08	***$194.68***
Employee and Family	$476.30	***$198.40***	$409.24	***$265.46***

CIGNA PPO LOW OPTION MEDICAL PLAN WITH CONSUMER CHOICE RX PLAN

	FULL-TIME		**PART-TIME**	
	30 hours or more per week		Between 20-29.99 hours per week	
	District Contribution Per Payday	Employee Cost Per Payday	District Contribution Per Payday	Employee Cost Per Payday
Employee	$199.92	***$52.06***	$104.38	***$147.60***
Employee and Spouse	$366.46	***$135.18***	$284.26	***$217.38***
Employee and Child(ren)	$308.78	***$106.28***	$222.06	***$193.00***
Employee and Family	$475.91	***$189.66***	$402.59	***$262.98***

DENTAL PLANS

EMPLOYERS DENTAL SERVICES (EDS)

A Managed Care Dental Organization

	FULL-TIME		**PART-TIME**	
	30 hours or more per week		Between 20-29.99 hours per week	
	District Contribution Per Payday	Employee Cost Per Payday	District Contribution Per Payday	Employee Cost Per Payday
Employee	$2.86	***$1.98***	$2.86	***$1.98***
Employee and Spouse	$5.42	***$3.76***	$5.42	***$3.76***
Employee and Child(ren)	$7.10	***$4.94***	$7.10	***$4.94***
Employee and Family	$8.18	***$5.68***	$8.18	***$5.68***

UNITED CONCORDIA

A PPO Dental Plan

	FULL-TIME		**PART-TIME**	
	30 hours or more per week		Between 20-29.99 hours per week	
	District Contribution Per Payday	Employee Cost Per Payday	District Contribution Per Payday	Employee Cost Per Payday
Employee	$8.96	***$6.24***	$4.84	***$10.36***
Employee and Spouse	$19.74	***$13.80***	$9.90	***$23.64***
Employee and Child(ren)	$21.38	***$14.90***	$11.86	***$24.42***
Employee and Family	$27.44	***$19.18***	$14.36	***$32.26***

AVESIS VISION STAND ALONE OPTION

Available only if enrolling for the medical waiver payment

100% Paid by Employee

	Employee Cost Per Payday
Employee	***$3.42***
Employee and Spouse	***$6.46***
Employee and Child(ren)	***$7.04***
Employee and Family	***$9.06***

SHORT-TERM DISABILITY PLAN

100% Paid by Employee

$1,000 weekly maximum

Short-Term Disability Options	**Rate Multiplier for 24 Pay Periods**
40% of Biweekly Base Salary*	$0.0035
50% of Biweekly Base Salary*	$0.0050
60% of Biweekly Base Salary*	$0.0065
70% of Biweekly Base Salary*	$0.0080

Short-Term Disability Example

Base Annual Salary: $25,000				
Base Annual Salary divided by 12 months = Monthly Salary	**$25,000 / 12 = $2,083.33**			
Base Monthly Salary: **$2,083.33**	**40% Option**	**50% Option**	**60% Option**	**70% Option**
Monthly Contribution = Base Monthly Salary (up to Maximum Base Monthly Salary) multiplied by Rate Multiplier	$2,083.33 X 0.0035	$2,083.33 X 0.0050	$2,083.33 X 0.0065	$2,083.33 X 0.0080
Monthly Contribution	**$7.29**	**$10.42**	**$13.54**	**$16.67**
Pay Period Contribution = Monthly Premium divided by 2	$3.65	$5.21	$6.77	$8.33

**Up to maximum benefit coverage*

LIFE INSURANCE

BASIC LIFE WITH ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D)

1 Times Base Salary – 100% Paid by Maricopa County Special Health Care District

SUPPLEMENTAL LIFE WITH ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D)

1 to 5 Times Base Salary – 100% Paid by Employee

Supplemental Life Insurance Table

5 Year Age Categories	Employee Cost per Payday Per $1,000 of Coverage	Employee Cost per Payday Per $1,000 of Coverage
	Smoker Multiplier	***Non-Smoker Multiplier***
Under 25	$0.0475	$0.0340
25-29	$0.0500	$0.0380
30-34	$0.0540	$0.0460
35-39	$0.0855	$0.0500
40-44	$0.1170	$0.0620
45-49	$0.2195	$0.1015
50-54	$0.3935	$0.1765
55-59	$0.4005	$0.2240
60-64	$0.6125	$0.3725
65-69	$0.7475	$0.5225
70 and older	$1.2175	$0.9575

Supplemental Life Insurance Example

1. Take your annual base salary – **Example: $24,500**

2. Round **up** to the nearest $1,000 and then multiply	1 X Salary	2 X Salary	3 X Salary	4 X Salary	5 X Salary
	$25,000	$50,000	$75,000	$100,000	$125,000
3. Take the Salary amount and divide by $1,000	25	50	75	100	125

4. Refer to the Supplemental Life Insurance table above to find your age category and cost multiplier

5. Multiply the results from the calculation in Step 3 by the multiplier.

Example: Age 37	***Multiplier for Smoking***	***Multiplier for Non-Smoking***	***Coverage Amount***
	$0.085500	***$0.050000***	
1 X Salary	$0.0855 X 25 = $2.14	$0.0500 X 25 = $1.25	$25,000
2 X Salary	$0.0855 X 50 = $4.28	$0.0500 X 50 = $2.50	$50,000
3 X Salary	$0.0855 X 75 = $6.41	$0.0500 X 75 = $3.75	$75,000
4 X Salary	$0.0855 X 100 = $8.55	$0.0500 X 100 = $5.00	$100,000
5 X Salary	$0.0855 X 125 = $10.69	$0.0500 X 125 = $6.25	$125,000

DEPENDENT LIFE INSURANCE

100% Paid by Employee

	Option One	Option Two
Spouse	$5,000	$10,000
Children, live birth to 14 days	$1,000	$1,000
14 days to 19 years, 25 years if full-time student	$2,500	$5,000
Employee Cost Per Payday:	***$0.92***	***$1.84***

2005 PAYROLL SCHEDULE USED FOR BENEFIT PREMIUM CALCULATIONS, COVERAGE BEGIN DATES AND COVERAGE END DATES

Pay Period	Beginning	Ending	Pay Day
1	December 20, 2004	January 2, 2005	January 7, 2005
2	January 3, 2005	January 16	January 21
3	January 17	January 30	February 4
4	January 31	February 13	February 18
5	February 14	February 27	March 4
6	February 28	March 13	March 18
7	March 14	March 27	April 1
8	March 28	April 10	April 15
9	April 11	April 24	April 29
10	April 25	May 8	May 13
11	May 9	May 22	May 27
12	May 23	June 5	June 10
13	June 6	June 19	June 24
14	June 20	July 3	July 8
15	July 4	July 17	July 22
16	July 18	July 31	August 5
17	August 1	August 14	August 19
18	August 15	August 28	September 2
19	August 29	September 11	September 16
20	September 12	September 25	September 30
21	September 26	October 9	October 14
22	October 10	October 23	October 28
23	October 24	November 6	November 10
24	November 7	November 20	November 23
25	November 21	December 4	December 9
26	December 5	December 18	December 23

2005 HOLIDAY SCHEDULE

Holiday	2005
New Year's Day	Friday, December 31
Martin Luther King Jr./Civil Rights Day	Monday, January 17
Presidents' Day	Monday, February 21
Memorial Day	Monday, May 30
Independence Day	Monday, July 4
Labor Day	Monday, September 5
Columbus Day	Monday, October 10
Veteran's Day	Friday, November 11
Thanksgiving Day	Thursday, November 24
Christmas Day	Monday, December 26

GLOSSARY OF ACRONYMS

Abbreviations used throughout this guide

A

AD&D: Accidental Death & Dismemberment
ADHD: Attention Deficit Hyperactivity Disorder
AHCCCS: Arizona Health Care Cost Containment System
ARS: Arizona Revised Statutes
ASI: Application Software, Inc.
ASRS: Arizona State Retirement System

B

BHSU: Behavioral Health Services Unit

C

CHC: Comprehensive Health Center
CMG: CIGNA Medical Group
COBRA: Consolidated Omnibus Budget Reconciliation Act
CPA: Clinical Prior Authorization
CST: Central Standard Time

D

DME: Durable Medical Equipment
DMR: Direct Member Reimbursement
DUR: Drug Utilization Review

E

EAP: Employee Assistance Program
EBAC: Employee Benefits Advisory Council
EBC: Electronic Business Center
EDS: Employers Dental Services
EIN: Employee Identification Number
ER: Emergency Room

F

FDA: Food & Drug Administration
FHC: Family Health Care
FMLA: Family Medical Leave Act
FML: Family Medical Leave
FSA: Flexible Spending Account

H

HIPAA: Health Insurance Portability and Accountability Act
HIV/AIDS: Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome
HMO: Health Maintenance Organization
HR: Human Resources

I

ID: Identification
IRC: Internal Revenue Code
IRS: Internal Revenue Service

L

LOA: Leave of Absence
LTD: Long-Term Disability

M

MAC: Maximum Allowable Charge
MIHS: Maricopa Integrated Health System
MST: Mountain Standard Time

N

NAIC: National Association of Insurance Commissioners
NCPDP: National Council for Prescription Drug Products
NEO: New Employee Orientation
NRS: Nationwide Retirement Solutions

O

OB/GYN: Obstetrician/Gynecologist
OOP: Out-of-Pocket
OTC: Over-the-Counter

P

PCP: Primary Care Physician
PCRA: Personal Choice Retirement Account
PHI: Protected Health Information
PML: Preferred Medication List
POS: Point-of-Service
PPO: Preferred Provider Organization
PSPRS: Public Safety Personnel Retirement System
PST: Pacific Standard Time
PTO: Paid Time Off

R

R&C: Reasonable and Customary
RIF: Reduction in Force
RN: Registered Nurse
RSV: Respiratory Syncytial Virus
Rx: Prescription

S

SPD: Summary Plan Document
SSN: Social Security Number
STD: Short-Term Disability

T

TMJ: Temporomandibular Joint

U

UBH: United Behavioral Health

W

WHI: Walgreens Health Initiatives

GLOSSARY OF MANAGED CARE TERMS

Change Form: An official document generated by the Benefits Office on which the employee requests a change to benefit elections due to a qualified status change.

Coinsurance: Under a health insurance policy, a cost-sharing requirement which provides that the insured assumes a portion or percentage of the costs of covered services after payment of the deductible.

Copayment: A cost-sharing arrangement in which the insured pays a specified dollar amount for a specific service (such as $15 for an office visit). The amount does not vary with the cost of the service unlike co-insurance, which is based on a percentage of cost.

Deductible(s): Amounts required to be paid by the insured under a health insurance contract, before the medical plan starts sharing in the cost of care and before benefits become payable.

Enrollment form: An official document generated by the Benefits Office on which the employee initially elects benefits.

Flexible Spending Account (FSA): Also referred to as Mariflex, this is a plan that provides employees with a way to set aside money on a pre-tax basis to cover the costs of health care expenses not covered under medical insurance coverage (medical, dental and vision) or dependent care expenses that enable the employee to work.

Health Maintenance Organization (HMO): HMOs offer comprehensive health coverage for both hospital and physician services. An HMO contracts with health care providers, e.g., physicians, hospitals, and other health professionals who participate in their network. The members of an HMO are required to use participating network providers for all health services and many services need to meet further approval by the HMO through its utilization program. HMOs are the most restrictive form of managed care benefit plans because they restrict the procedures, providers, and benefits.

Healthplan Medical Director: A physician employed by the Healthplan to assist in managing the quality of the medical care provided by participating providers in the Healthplan's network.

Insured: A person or organization covered by an insurance policy.

Insurer (Insurance Company): A corporation, such as CIGNA HealthCare of Arizona, engaged primarily in the business of furnishing insurance to the public.

Medical Waiver Payment: Compensation paid to the employee by the County if medical coverage is not elected because of enrollment in other group health insurance. Waiving medical coverage means waiving coverage for all components of the medical plan, which includes medical, vision, prescription, behavioral health and substance abuse benefits.

Network or In-Network: Health care provided by a doctor, hospital, pharmacy, or other health care provider with whom the plan has contracted to provide services at specified fees. Under the CIGNA HMO and POS plans, and the HealthSelect plan, the insured must choose a network primary care physician and have care coordinated by their primary care physician to qualify for in-network benefit.

Out-of-Network: Health care received from a provider who is not contracted with the insured's medical plan network, or, if a primary care provider is required, care that is not authorized by the insured's primary care provider and their medical plan.

Out-of-Pocket Maximum: The maximum amount the insured pays each year for health care. After their share of eligible expenses has reached the plan's out-of-pocket limit per person or per family, the plan pays the full cost of their eligible expenses for the rest of that year. The out-of-pocket maximum does not include any copayments, pharmacy or mental health/substance abuse treatment expenses, or non-certification penalties.

Participating Provider: Also referred to as "contracted provider" or "in-network provider", the physician, institution, hospital, ancillary professional or vendor contracted with the health plan to deliver care and services to health plan members.

Payment Agreement: A written agreement between the employee and the Benefits Office wherein the employee agrees to the timeframe of payment of benefit premiums while on an unpaid leave of absence in order for benefits coverage to continue.

PCP (Primary Care Physician): A physician who practices general medicine, family medicine, internal medicine, or pediatrics who, through an agreement with the insurer, participates in the network, provides basic health care services and arranges specialized services.

Point-of-Service Plan (POS): A point-of-service plan gives options each time the participant needs medical care. Providers and coverage level may be chosen at the time of service. When the insured's Primary Care Physician (PCP) coordinates medical care, only a copayment for office visits is charged. Out-of-pocket costs for hospital and outpatient care are lowest. Authorization is necessary for hospitalizations and some types of outpatient care. There are no claims to file. The PCP handles everything. When care is received from a provider who is not in the insurer's network or care is received without getting a referral from the PCP, out-of-pocket costs will be higher, and some services may not be covered. Authorizations and filing of claims become the responsibility of the insured. An annual deductible must be met and then covered services are paid up to the plan's reasonable and customary amounts. Coverage of pre-existing conditions may be limited.

Preferred Medication List: Varying list of prescription drugs approved by a health plan or a pharmacy benefit manager for distribution to an insured through specific pharmacies.

Preferred Provider Organization (PPO): A preferred provider organization is a plan that allows the insured to access medical services directly without coordinating care through a primary care physician (PCP). The plan offers a broad national network of providers. When care is received by a provider who is participating in the insurer's network, out-of-pocket expenses are lower. When care is received by a non-participating provider, costs are higher. Not all services are available outside the network. Coverage of pre-existing conditions may be limited.

Reasonable and Customary Charge (R&C): The prevailing charge of most other providers in the same or similar geographic area for the same or similar service. If the insured receives non-network services and the provider's fee is more than the R&C charge, the insured will have to pay 100 percent of the charges over R&C. When network care is received, the eligible expenses are determined from the network provider's contracted rate.

Short-Term Disability (STD) Benefits: Short-term disability (STD) pays a percentage of the employee's salary if he/she becomes temporarily disabled due to sickness or injury and is not able to perform the essential functions of the job. The employee must be under the regular care and treatment of an appropriate provider. The STD plan provides a weekly portion of the employee's salary for up to 23 weeks following a minimum 21-day elimination period.

Term life insurance: Term life insurance covers a person against death for a limited time-a term. In the case of the term life insurance coverage provided by UNUMProvident, the term is conditional. You are covered as long as you are employed with Maricopa County.

WHO TO CONTACT

EFFECTIVE JANUARY 1, 2005

COMPANY	PHONE	WEB SITE & E-MAIL ADDRESSES
Employee Benefits		
Maricopa County Benefits Office Maricopa County Administration Building 301 West Jefferson St., Suite 201 Phoenix, Arizona 85003-2145	602-506-1010 **Fax:** 602-506-2354 **Fax:** 602-372-8548	**Internet**: www.maricopa.gov/benefits **Intranet**: ebc.maricopa.gov/hr/benefits **E-mail:** BenefitsService@mail.maricopa.gov
Medical Plans		
CIGNA Customer Service (HMO, POS and PPO) Group # 3205496	800-244-6224	**Internet**: www.cigna.com **Internet**: www.mycigna.com
HealthSelect Customer Service Group # 3310592	800-244-6224	**Internet**: www.maricopa.gov/benefits www.mycigna.com and www.cigna.com **Intranet**: ebc.maricopa.gov/hr/benefits **Intranet:** www.maricopa.gov/medcenter/healthplans (for provider directory)
24-Hour Health Information Line (for CIGNA and HealthSelect members)	800-564-8982	
Pharmacy Plan		
Walgreens Health Initiatives Member Services Group # 512229 Prior Authorization Walgreens HealthCare Plus' Mail Order Member Service Mail Order Refills	800-207-2568 877-665-6609 888-265-1953 800-797-3345	**Internet**: www.mywhi.com
Behavioral Health		
United Behavioral Health (for HealthSelect and all CIGNA medical plans except CIGNA Low Option PPO) Group # 12488	866-312-3078	**Internet**: www.liveandworkwell.com Access Code 12488
CIGNA Behavioral Health (for Low Option PPO) Group # 3205496	800-244-6224	**Internet**: www.cigna.com **Internet**: www.mycigna.com
ComPsych Guidance Resources: EAP	888-355-5385	**Internet**: www.guidanceresources.com ID: MC2003
Vision		
Avesis (for HealthSelect and all CIGNA medical plans) Plan # 943 Group # 910790-95-01 (all medical plans) Group # 10790-2016-943 (if waived medical coverage and elected stand alone vision)	800-828-9341	**Internet**: www.avesis.com **E-mail:** info@avesis.com
Dental		
Employers Dental Services Group # 11931	602-248-8912 800-722-9772	**Internet**: www.mydentalplan.net
United Concordia Group # 815151	800-332-0366	**Internet**: www.ucci.com
Life Insurance		
UNUMProvident Customer Service Life Group # 584741 AD&D Group # GSR 36743 and GSR 36744	800-421-0344	**Internet**: www.unum.com
Short-Term and Long-Term Disability		
VPA, INC Short-Term Disability, Plan # 435000 Long-Term Disability	 800-599-7797 800-495-9301	**Internet**: www.vpainc.com
Other Frequently Requested Information		
Arizona State Retirement System Outside Phoenix	602-240-2000 800-621-3778	**Internet**: www.asrs.state.az.us
Public Safety Retirement System	602-255-5575	**Internet**: www.psprs.com
ASI (Mariflex Administrator): Flexible Spending Accounts	800-659-3035	**Internet**: www.asiflex.com **E-mail:** asi@asiflex.com
Liberty Mutual: Auto, Home and Renters Insurance	800-221-8135	**Internet**: www.libertymutual.com
Nationwide Retirement Solutions: Deferred Compensation	602-266-2733 800-653-4632	**Internet**: www.maricopadc.com
Trustmark: Critical Illness Coverage	480-991-4444, ext. 15	**E-mail:** enrollment@einsteinbenefit.com
CompuSys COBRA Administrator	602-234-0497	**E-mail:** mccobra@compusysaz.com